Interpreting Practices in Health Care: An Investigation of Differences across Trained and Untrained Interpreters in Initial Assessment Interviews, within the Field of Speech-Language and Hearing Therapy

University of Cape Town

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ABSTRACT

Interpreting is an act that has become so customary within the South African context that it has become virtually invisible. Most health care institutions rely on *ad hoc* interpreting, which involves haphazard interpreting arrangements in which anyone who speaks the patient's language, is called on to interpret. Untrained interpreters are consistently used in clinical practice due to a severe lack of trained interpreters. Despite this, to date little research has been conducted investigating the differences between trained and untrained interpreters. Furthermore, little research has been undertaken on the use of interpreters in the field of Speech-Language and Hearing Therapy. There is much need for interpreters within our profession, as clinicians usually either speak English or Afrikaans, with very little or no knowledge of indigenous South African languages. In this study, differences between trained and untrained interpreters were examined in the initial assessment interview, within the field of Speech-Language and Hearing Therapy. Multiple methods of analyses were used, including interviews with informants, systematic observation of recorded sessions and systematic discourse analysis of the potential positive and negative contributions of the trained and untrained interpreters' mistranslations. The latter was achieved with the use of a Revised Mistranslation Analysis Tool, which recognises that mistranslations could have negative as well as positive contributions. Findings from this study revealed that mistranslations occurred most frequently in the untrained interpreted interviews, and their contribution was largely negative, while the contribution of the mistranslations in the trained interpreted interviews was largely positive. Contribution varied as a function of type of mistranslation across trained and untrained interpreted interviews. Differences were noted in the strategies used to facilitate understanding and accuracy between the trained and untrained interpreted interviews. Furthermore, differences were noted in the interpersonal interaction, display of empathy, use of non-verbal behaviours, and the roles portrayed by the trained and untrained interpreters within the interpreted interviews. The results from this study clearly indicated the need for formal training and professionalisation of interpreters. Furthermore, field-specific knowledge emerged as an important consideration when training interpreters. The contribution of the clinician in the interpreted interview was well recognised and the need for training clinicians in working with interpreters was also established. In line with the findings from this study, preliminary guidelines for the training of clinicians and

University of Cape Town

CONTENTS

ABSTRACT..... i
CONTENTS..... ii
LIST OF TABLES..... vii
LIST OF FIGURES..... viii

1. INTRODUCTION..... 1

2. METHODOLOGY..... 14

2.1 Aims..... 14

2.2 Research Design..... 14

2.3 Informants..... 15
2.3.1 Selection Criteria..... 16
2.3.1.1 Clinician..... 16
2.3.1.2 Interpreters..... 16
2.3.1.3 Caregivers..... 17
2.3.2 Informant Description..... 17
2.3.2.1 Clinician..... 17
2.3.2.2 Interpreters..... 17
2.3.2.3 Caregivers..... 19
2.3.2.4 Description of Programmes..... 20
2.3.2.5 Job Description of the Community Interpreter..... 23
2.3.2.6 Informed Consent..... 23
2.3.3 Pilot Study..... 23

2.4 Data Collection: Procedure and Materials..... 24
2.4.1 Procedure..... 25
2.4.1.1 Setting..... 25
2.4.1.2 Time..... 26

University of Cape Town

2.4.1.3 Interview Recording and Equipment..... 26
2.4.2 Materials..... 26
2.4.2.1 The Initial Assessment Interview Questions..... 27
2.4.2.2 Construction of the Questionnaires for the Post-interview Sessions..... 27

2.5 Treatment of Data..... 32
2.5.1 Transcription of Raw Data..... 33
2.5.2 Translation of Raw Data..... 33

2.6 Analysis of Data..... 33
2.6.1 Analysis of the Transcribed Data from the Initial Assessment Interviews..... 33
2.6.1.1 Description of the Revised MAT..... 34
2.6.1.2 Components of the Revised MAT..... 35
2.6.1.3 Definitions of the Components of the Revised MAT..... 37
2.6.1.4 Layout of the Revised MAT..... 39
2.6.1.5 Procedure for Analysing Data from the Revised MAT..... 41
2.6.2 Data from the Semi-structured Interviews..... 42

2.7 Reliability..... 46
2.7.1 Confirming the Accuracy of the Transcription and Translation of the Data... 46
2.7.1.1 Xhosa Data..... 46
2.7.1.2 English Data..... 48
2.7.2 Confirming the Accuracy of the Preparation of Data for the Mistranslation Analysis..... 49
2.7.2.1 Intra-rater Reliability..... 49
2.7.2.2 Inter-rater Reliability..... 49
2.7.3 Confirming the Accuracy of the Mistranslation Analysis..... 50
2.7.3.1 Intra-rater Reliability..... 50
2.7.3.2 Inter-rater Reliability..... 50
2.7.4 Validating the Data at the Level of Thematic Analysis..... 50
2.7.4.1 Data on Characteristics of the Informants..... 50
2.7.4.2 Audit Trail..... 51
2.7.4.3 Triangulation..... 51

University of Cape Town

2.7.4.4 Subjective Assessment of the Interviews Immediately After the Recording... 53
2.7.4.5 Missing Data..... 54

3. RESULTS AND DISCUSSION..... 55

3.1 Transaction..... 56
3.1.1 Accuracy..... 57
3.1.1.1 Number of Accurate vs. Inaccurate Translations across Trained and Untrained Interpreted Interviews..... 58
3.1.1.2 Type of Mistranslations: Additions and Omissions..... 60
3.1.1.3 Contribution of Mistranslations..... 63
3.1.1.4 Causes of Mistranslations..... 66
3.1.1.5 Reasons for Accurate Translations..... 83
3.1.1.6 Effect of Direction..... 90
3.1.2 Understanding 92

3.2 Interaction..... 95
3.2.1 Interpersonal Interaction and Comfort..... 95
3.2.2 Non-verbal Behaviour..... 99
3.2.3 Empathy..... 105
3.2.4 Innate Qualities of Interpreters..... 108
3.2.5 Cultural Issues..... 109

3.3 Need for Interpreters in Health Care..... 112

3.4 Roles of the Interpreter..... 118

3.5 Training..... 127
3.5.1 Need for Field-specific Training..... 127
3.5.2 Content and Skills Acquired During Training..... 129
3.5.3 Training of Health Care Professionals..... 131
3.5.4 Guidelines for the Training of Interpreters and Clinicians Working with Interpreters..... 132

University of Cape Town

3.6 Satisfaction..... 135

4. GENERAL DISCUSSION..... 137

4.1 Need for Linguistically Equitable Service Provision in Health Care..... 139

4.1.1 Need for Black Clinicians and for Clinicians to Learn an Indigenous Language..... 139

4.1.2 Need for Policy Formation..... 144

4.1.3 Need for Training and Professionalisation of Interpreters..... 149

4.1.4 Need for Training of Clinicians in Interpreting Practices..... 154

4.1.5 Need for Genuine Commitment from Stakeholders..... 156

5. CONCLUSIONS AND IMPLICATIONS..... 158

5.1 Theoretical Implications..... 162

5.2 Clinical Implications..... 163

5.3 Future Research Implications..... 164

6. ACKNOWLEDGMENTS..... 166

7. REFERENCES..... 168

8. APPENDICES..... 182

University of Cape Town

LIST OF TABLES

Table 2.1: Biographical Details of the Clinician..... 17
Table 2.2: Biographical Details of the Trained Interpreters..... 18
Table 2.3: Biographical Details of the Untrained Interpreters..... 18
Table 2.4: Biographical Details of the Caregivers..... 20
Table 2.5: Components of the Interpreter Training Programme..... 22
Table 2.6: Themes Included in the Questionnaires..... 28
Table 2.7: Components of the Participant Interpreter's Training..... 31
Table 2.8: Inter-rater Transcription Reliability..... 48

Table 3.1: List of Themes..... 55
Table 3.2: Proportion of Variation of Accurate vs. Inaccurate Translations within Trained (TI) and Untrained (UI) Interpreted Interviews..... 75
Table 3.3: Reasons for Accurate Translations..... 84
Table 3.4: Guidelines for the Training of Interpreters..... 133
Table 3.5: Guidelines for the Training of Clinicians Working with Interpreters..... 134

University of Cape Town

LIST OF FIGURES

Figure 1	The Data Collection Procedure.....	25
Figure 2	The Revised Mistranslation Analysis Tool.....	40
Figure 3	Flow Diagram Depicting the Revised MAT Analysis Procedure.....	41
Figure 4	Flow Diagram Depicting the Stages Involved in the Data Analysis.....	43
Figure 5	Flow Diagram Depicting the Stages Involved in Confirming the Accuracy of the Xhosa Data.....	47
Figure 6	Formula for Inter-rater Reliability.....	48
Figure 7	Proportion of Accurate vs. Inaccurate Translations across Trained and Untrained Interpreted Interviews.....	59
Figure 8	Number of Mistranslations According to Type - Additions and Omissions.....	60
Figure 9	Proportion of Positive to Negative Mistranslations across Trained and Untrained Interpreted Interviews.....	63
Figure 10	Contribution of Additions across Trained (TI) and Untrained (UI) Interpreted Interviews.....	65
Figure 11	Contribution of Omissions across Trained (TI) and Untrained (UI) Interpreted Interviews.....	65
Figure 12	Proportion of Negative Mistranslations caused by Textual and Non-textual Factors across Trained and Untrained Interpreted Interviews.....	67
Figure 13	Number of Mistranslations According to Textual Factors across Trained and Untrained Interpreted Interviews.....	68
Figure 14	Number of Mistranslations According to Non-textual Factors across Trained and Untrained Interpreted Interviews.....	73
Figure 15	Relative Effects of Cultural Brokerage and Attempts to Increase Understanding as Causes of Positive Mistranslations across Trained and Untrained Interpreted Interviews.....	81
Figure 16	Percentage of Mistranslations According to Session Direction across Trained and Untrained Interpreted Interviews.....	90
Figure 17	Seating Arrangements during the Initial Assessment Interviews.....	102

University of Cape Town

1. INTRODUCTION

Interpreting practices have received much attention internationally, in line with the recognition of the need for linguistically and culturally appropriate service provision in all aspects of the public sector.

South Africa in particular, is a country rich in terms of its multilingual diversity and the majority of its citizens can be placed along a continuum of multilingualism (Penn & Beecham, 1992). There is not only a large variety of African, Asian and European languages in South Africa, but also the accepted variations of these languages (Reagan, 1995). As noted by Schuring (1993), only 32% of Black South Africans speak English and 29% speak Afrikaans[1]. However, English and Afrikaans remain the two most prominent languages spoken in the public sector. Hence, the need for interpreting services to be made available to the majority of the South African population is clear. This is particularly noticeable in the area of health care services, where the provision of interpreting services is sorely lacking.

Xhosa speakers have long been neglected in the provision of health care by virtue of both their race and the language they speak (Drennan, 1999a). In South Africa, there is a vast language divide in all spheres of health care between patients and their clinicians. The majority of clients treated at government hospitals are Afrikaans or Xhosa speaking (Kaschula & Anthonissen, 1995). This is a result of the overwhelming majority of health professionals, with the exception of the nursing profession, being unable to speak any of the *indigenous languages*[2] (Drennan, 1998). The absence of a common language amongst the majority of doctors and patients is so much a part of the everyday experience of health care provision in South Africa, that it has become almost invisible (Drennan, 1999a). Thus, the so-called 'language gap' and routinised strategies attempting to compensate for it, have become institutionalised, and even ritualised aspects of the everyday practice of health care (Swartz, 1991a).

[1] See Appendix A for a tabulation of the official languages in all nine provinces in South Africa.

[2] The term *indigenous languages* refers to all the official South African languages, with the exception of English and Afrikaans. This term is interchangeable with the term *Black African languages*, but not with the term *African languages* as Afrikaans is considered to be an African language (Drennan, 1998).

University of Cape Town

Hospitals and regions differ in terms of the unwritten conventions as to how the work of interpreting will be accomplished, but most seem to rely on haphazard or *'ad hoc'* interpreting arrangements in which anyone who speaks the patient's language is called on to interpret (Swartz, 1992; Crawford, 1994; Muller, 1994; Ngqakayi, 1994; Drennan, 1996a, 1998). Despite the *'ad hoc'* appearance of the interpreting situation, there has always been a degree of informal organisation in particular settings (Crawford, 1994). Thus, while interpreting has been recognised as a fundamental aspect of providing health services to Black patients, at best it has been left to nurses to fulfil this role, at worst to fellow patients or family members (Drennan, 1998). In fact, nurses have come to view interpreting as incidental and daily aspect of their work (Herselman, 1994). It has been documented that accessibility and quality of services deteriorates when 'ad hoc' interpreting practices using unqualified individuals are employed (De Ridder, 1999). Drennan (1999a) adds that without the use of trained interpreters, speakers of indigenous languages are multiply disadvantaged. Despite this, the reality is that untrained interpreters are consistently used in clinical practice due to a severe lack of trained interpreters.

This situation is not just specific to South Africa but has applications internationally (Andreyev, 1987; Fernando, 1988; Kline, Acosta, Austin & Johnson, 1990; Baker, Hussain & Saunders, 1991; Vasquez & Javier, 1991; Drennan, 1998; Bowen, 2000). However, it is well recognised that the extent of the interpreting problem in South Africa, is of a greater scale and complexity than in other parts of the world, owing to the multicultural, multilingual nature of the populace in South Africa (Erasmus, 1999). To meet the immediate needs of the South African population, the use of *community interpreters*[3] has been established, primarily because of the multilingual nature of the population, as well as the relatively deprived level of education of the majority of the population (Lesch, 1999).

With the enactment of the Interim Constitution (1993), South Africa developed from an officially bilingual country to one with eleven official languages. The rights of the previously disadvantaged languages were to be extended, and one of the principles that

[3] A *'community interpreter'* is responsible for *"enabling professional and client, with very different backgrounds and perceptions, and in an unequal relationship of power and knowledge, to communicate to their mutual satisfaction"* (Shackman, 1987, p.18 in Boloka, 1999).

University of Cape Town

was to be implemented by the South African authorities referred specifically to the promotion of multilingualism and the provision of translation facilities (See Appendix B1, Section 3 [9] (d), 1993 Constitution). However, the final draft of the South African Constitution (1996) saw the disappearance of the above-mentioned principle, and was replaced by the requirement that at least two official languages are used for government purposes (See Appendix B2, Section 6 (3), 1996 Constitution). In addition, the extension of language rights determined in the 1993 Constitution was replaced by the requirement that the state applies itself to the objective of raising the status and expanding the usage of the historically disadvantaged languages (See Appendix B2, 1996 Constitution). Furthermore, as Du Plessis (1999) stated, it cannot be ignored that the constitutional stipulations with respect to language give expression to an endeavour to establish a multilingual system.

Thus, the South African Constitution clearly provides a guideline for the development of indigenous languages. This has led to the development of a number of structures and bodies, the most significant amongst them being the Pan South African Language Board (PANSALB), a statutory board whose purpose is to implement this directive. As stipulated above, there is no reference to the provision of translation facilities in the new Constitution (1996), however, these principles were in fact retained in the legislation relating to PANSALB in Section 3, Act 59 of the PANSALB Act (1995). Thus, the responsibility for enforcing such principles has now, by implication been shifted from the legislative and executive authorities to PANSALB, who is an advisory body without any legislative powers (Du Plessis, 1999). Thus the board must work in consultation with the public service in order to ensure that a translation and interpreting infrastructure is established and maintained, along with the resources needed for the purpose of the promotion of multilingualism, and the provision of translation and interpreting facilities (Du Plessis, 1999).

The Language Plan Task Group (LANGTAG) was commissioned in November 1995 to develop a national language plan for South Africa. LANGTAG submitted a final report (LANGTAG, 1996), which is of great importance to the translation and interpreting professions, since an entire section is devoted to these fields and pertinent recommendations were made (Drennan, 1998).

University of Cape Town

Clearly, the post-apartheid era is marked by a process of transformation. During this period, multilingualism and multiculturalism are emerging and being promoted. These concepts are largely supported by the South African Constitution, which enshrines the right of each individual to be addressed in the language of his or her choice, and the principle that all cultures should be respected (Ntshona, 1997). For the first time, indigenous languages are officially recognised and these languages have, in constitutional terms, equal value with English and Afrikaans (Swartz & Drennan, 2000). It is envisaged that the process of informing and empowering marginalised communities through interpreting services will make a significant contribution towards narrowing the communication gap (Ntshona, 1997). However, as Ntshona suggests (1999), the reality of the South African situation is that the process of change is long and tedious. In newly integrated services, overt disadvantage due to race has been replaced by covert disadvantage due to linguistic and cultural barriers. Furthermore, Heugh (1995) uses the term "linguicism" to describe ideologies and structures which reproduce unequal division of power and resources between groups on the basis of language (Heugh, 1995, p. 333).

Beukes (1995) points out that the role of language in development has not yet been properly deliberated and she emphasises that a language policy strategy to achieve *functional multilingualism* must be adopted. Du Plessis (1999) states that there is a need for the transformation of the translation and interpreting industry in South Africa. He suggests that translation and interpreting services should be expanded to make provision for the indigneous languages and to meet the new demands of the new South Africa. Furthermore, training programmes need to be amended accordingly, as well as to be made more accessible, and should be presented at various levels so as to meet divergent needs. Du Plessis (1999) further indicates that the state should play a key role in creating new infrastructure for translation and interpreting in South Africa. Thus, although there has been much acknowledgement of the stipulations in the South African Constitution (1996), there appears to be a gap between policy and implementation of linguistically equitable service provision, particularly in health care.

Since language is an essential determinant of access to resources, the new Constitution's resolution that South Africa will have eleven official languages should imply that language policy must now receive urgent attention at the level of service provision (Erasmus, 1999). However, within the health sector, the issue of communication problems

University of Cape Town

and the language question in relation to access of services, have as yet hardly featured on the agenda of public discussion. Despite financial constraints, lack of implementation of language policies as well as the rights of individuals to be treated equitably need to be addressed. As Du Plessis (1999) points out, the lack of preparation for meeting the needs of the South African Constitution has resulted in a crisis situation.

It is not surprising that the legacy of the under-provision of facilities and the maldistribution of resources in health care as a whole, would be reproduced in the area of language services in health care (Crawford, 1994; Drennan, 1996b). However, larger political changes and indigenous languages becoming official create a climate more favourable to redressing service inadequacies (Drennan, 1996b). As Drennan (1998) suggests, the abolition of apartheid legislation and the establishment of a new Bill of Rights within a new South African Constitution presents a unique opportunity for health services in South Africa. The fact that functional multilingualism is now being promoted, implies that translators and interpreters have an important role to play and have reason to be optimistic. However, although there is currently an attempt to establish a functional multilingual system, what is currently lacking is a clear plan of action (Du Plessis, 1999).

Recently, in line with the shift in the recognition of linguistic rights of all South Africans, there has been a concurrent shift in health care reform, albeit in its infancy. The need for culturally and linguistically appropriate service provision in the public sector, with an extension into the communities of the majority of the population has been addressed. As a result of this shift, there has been an acknowledgement of the need for interpreting services in health care, but once again no clear plan of action has been suggested or implemented.

From a review of the literature, over the past decade, in line with these shifts in the recognition of equitable service provision and health care reforms, research in the field of interpreting within health care has flourished. To date, a large number of health-related professions have acknowledged the need for interpreters within health care and have conducted research relating to interpreting issues within their specific fields. These include the fields of psychiatry and clinical psychology, (Crawford, 1994; Drennan, 1992, 1996a, 1996b, 1998, 1999b; Muller, 1994; Swartz, 1986, 1987, 1991a, 1991b, 1992, 1996, 1998), medicine (Wood, 1993), dietetics (Bal, 1981), social work (Devenish, 1999),

University of Cape Town

pharmacy (Smit, 1999) and nursing (Herselman, 1994; Elderkin-Thompson, Silver & Waitzkin, 2001) and public health (Petros, 1999 in Ntshona, 1999).

Initially, the bulk of research undertaken has focused on the accuracy of the interpreting process, particularly as it would impact upon diagnostic assessment and management (Muller, 1994). Several researchers have primarily highlighted the negative impact associated with using interpreters, referring to "alterations in meaning" (Price, 1975, p.263), "interpreter error" (Price, 1975; Vasquez & Javier, 1991), "mistranslations" (Price, 1975; Ebden, Carey & Bhatt, 1988), "distortions" (Marcos, 1979, p. 173) and "illegitimate deviances" (Launer, 1978, p. 934). However more recently, there has been an acknowledgement of examining interpreters in a more positive light. This is primarily in lieu of the fact that focusing on a narrow conception of inaccuracy obscures the remarkable accomplishments of actors in their routine production and recognition of everyday communications (Heritage, 1984 in Drennan, 1998; Penn, 2000; Evans, 2000).

Consequently, research focus has shifted from concern about the quality of interpreting to a concern for the appropriacy and accessibility of the translation (Siegrun, 1992 in Lesch, 1999). Thus the emphasis has moved away from purely examining the problems associated with using interpreters, to how interpreters can meet the needs of the communities they serve.

Although much past research has also focused on the role of the interpreter, to date the role of the interpreter in health care is still ill defined. As has been suggested by Bowen (2000), this may be another factor contributing to a lag in linguistically equitable service provision in the health sector. While the responsibility of an interpreter is to bridge the linguistic barrier between individuals speaking different languages in order that they may communicate freely with each other, there is no consensus on the best way to achieve this (Bowen, 2000). Drennan (1998) acknowledges that interpreters are invariably subject to the stresses attendant on fulfilling a function for which there is a lack of definition. There is an ongoing debate regarding what exactly is meant by 'interpretation', how broadly the interpreter's role can be defined and whether objective language 'translation'[4] can or

[4] As defined by The World Book Dictionary (1994), *interpreting* refers to 'the act of explaining', while *translating* is more linguistic in nature and refers to 'the act of changing from one language to another'.

University of Cape Town

should be combined with other roles, such as that of cultural broker, educator, mediator or advocate.

Kaufert & Koolage (1984) attest to the multiple and often conflicting roles that interpreters play within an institution. This is primarily due to the differing expectations of the institution they work within, as well as the patient and clinician within the interpreted interview. For example, interpreters within psychiatric institutions have been expected to do counselling, interpreting, advocacy work as well as functioning as a member of a multidisciplinary team (Drennan, 1998). This debate has emphasised crucial issues for service provision in health care that cannot be easily resolved (Downing, 1995 in Bowen, 2000). It highlights both the complexities of the interpreter's role as well as the challenge and need for 'measuring' the efficacy of interpreters in the provision of health care services. What is surprising is that little research has focused on the effects of interpretation on the interpreters themselves, and their perspectives are often not included in planning or research (Bowen, 2000).

Theoretical models that have been developed to describe the roles that interpreters play and the interaction that occurs in the triangular doctor-interpreter-patient relationship, extend from that of a linguist on the one end of the spectrum to that of a cultural broker and patient advocate on the other end of the spectrum.

Previously, little of the substantive body of work on doctor-patient interactions has been applied to the use of interpreters in these interactions (Wood, 1993). This is perhaps because interpreters have been expected to function as a linguistic robot or 'black box' (Westermeyer, 1990) in the process of bridging disparate discourses, that their role in accomplishing and enabling communication has been somewhat taken for granted (Drennan, 1998). The 'black box' model of interpreting is in line with an empiricist view of language, as suggested by Good & Good (1980 in Swartz, 1998). The empiricist approach views language as a means of assigning different sets of labels for realities which are common across the world (Swartz, 1998). Thus in this model, the interpreter's role would be purely that of substituting words from one language to another. Contrastly, the hermeneutic approach views language as playing a part in meaning (Swartz, 1998). This model is more in line with acknowledging the complexity of the interpreting situation. Only with the consideration of the social and cultural dimension of interpreter

University of Cape Town

function has their position in relation to linguistic, medical and cultural bodies of knowledge begun to be re-examined and problematised (Kaufert & Koolage, 1984; O' Neil, 1989).

The role of the interpreter as a cultural broker is considered to be particularly useful in the provision of health care services in multicultural settings. Cultural brokerage primarily concerns the establishment of meaningful links between socio-culturally differentiated groups whenever there is a need to establish such ties between such groups (Herselman, 1994). Cultural brokerage has also been used to suggest advocacy for economically marginalised persons in relation to a larger community (Chambers, 1985 in Herselman, 1994). However, it presupposes considerable knowledge of the cultures involved to ensure objectivity in analysis or interpretation of the problematic situations (Van Willigen, 1986). Clearly, effective cultural brokerage is not a task that could be easily undertaken without the necessary training in cross-cultural and multicultural issues.

Advocacy is another role of interpreters that has received much recognition. Advocacy is considered necessary for patients with different cultures and languages than the professionals that are assisting them. Advocacy models of interpreting vary from the interpreter acting as a social worker or lay psychologist to the interpreter being part of a 'professional team' (Erasmus, 1999). As mentioned previously, this model of interpreting is also sometimes known as the *'community interpreting'*[5] approach, because of the emphasis on community needs and questions of power relationships across communities. In the South African context, much attention has been paid to the establishment and recognition of community interpreters by Erasmus (1999) and her colleagues.

Furthermore, there is currently much debate regarding the position of the interpreter within an institution, and more specifically regarding the expected neutrality of the interpreter (De Ridder, 1999). De Ridder (1999) states that neutrality is considered to be a cornerstone of professional interpreting. However, an ethnomedical approach to understanding the role of an interpreter in negotiating with patients, must consider values and the ways that the process of making decisions are shaped by one's culture. In clinical

[5] The term *community* when used within a *community interpreting approach*, does not refer to a geographical community, but to an approach, whereby the needs of the community are addressed (Lesch, 1999).

University of Cape Town

situations that involve decision-making, the role of the interpreter is not simply to interpret ethical issues in an objective and linguistically accurate manner (Kaufert & Putsch, 1997). In addition, interpreters may influence interaction with patients more directly, serving as mediators between clinicians and patients, explaining patient's values and assisting in negotiating an ethical contract. This is a clear departure from the concept of an objective uninvolved intermediary. It is however proposed that this is a reality that challenges the notion that interpretation can be consistently neutral (Kaufert & Putsch, 1997). In addition, policies or institutions that restrict the role of the interpreter and emphasise cultural neutrality and invisibility may ignore other critical dimensions of the interpreter's activities in health care. Thus, a paradox is created, because as familiarity with an institution increases, the interpreter is able to establish credibility, trust respect and confidentiality (Drennan, 1998), but conversely, this increased familiarity can result in increased loyalty to the establishment, which might compromise the autonomy of the interpreter.

Furthermore, the multitude of problems associated with the practice of interpreting are being reflected on in different ways. Previously, researchers have referred to interpreting error as a result of the interpreter's lack of knowledge in a number of crucial areas. Focus has shifted from blaming the interpreter to acknowledging the role and contribution of the clinician in the interpreted interview (Muller, 1994), as well as the role of the institution as a whole (Drennan, 1998, 1999b). Thus, there has been a growing recognition of the complexity of the interpreting situation (Swartz, 1991a, 1998).

Past research has largely failed to acknowledge the role of the clinician in the interpreted interview. As Bowen (2000) suggests, even with skilled interpretation, optimum quality of communication cannot be achieved without the clinician's awareness of the need for and competence to work effectively with interpreters. Thus, it appears that an additional challenge related to training is the need for training of clinicians in working with interpreters. It is clear that health care providers are faced with an overwhelming number of issues related to the gap in culture and language proficiencies, and the lack of trained, professional interpreters. Relatively few health care facilities in South Africa are sufficiently prepared to deal with the array of cultural problems they are faced with in their clinical settings (Nguyen, 1999). This suggests the need to look more carefully at the role of the clinician in interpreted interviews as well as the need for the development of

University of Cape Town

training guidelines for clinicians working with interpreters, that address cross-cultural and multicultural issues.

Furthermore, despite the acknowledgement of the complexity of the interpreted interview, past research on interpreting practice has failed to sufficiently investigate the views of the patients or caregivers, which is surprising considering that they are the ones that are most disadvantaged by disorganised and unstructured interpreting practices. It is proposed that this is possibly due to the persistence of historically entrenched political ideologies that indigenous languages be suppressed, and thus speakers of these languages have no channel through which to voice their convictions.

Recently, the need for professional accreditation of interpreters has received much attention (Blaauw, 1999; Marais, 1999; Niska, 1999b, Bowen, 2000). Central to the current status and use of interpreters is the issue of professionalism. At present, South Africa lacks standardised qualifications and accreditation systems (Marais, 1999). These factors are thought to be partially responsible for the low status of interpreters and their lack of acknowledgement in health care services, as well as the undermining of the existing interpreting services. Accreditation generally involves a test of skill that is external to any course taken, and as such is a mechanism of ensuring equivalent standards across a variety of training programs (Bowen, 2000). As Bowen (2000) suggests, it is important that accreditation be coordinated at the national level, and that the process incorporates both the complexity and the scope of the interpreter's role.

University of Cape Town

Professionalisation and training of interpreters are closely linked, since professionalisation cannot be established without the appropriate training of interpreters. Recently, these issues have received increased attention internationally as well as locally. There is much information on interpreter training programmes, which have been developed specifically for the South African situation, based on local needs and international expertise (Freimanis, 1994; Swartz & Maw, 1994; Corsellis, 1999b; Erasmus & Mathibela, 1999; Lotriet & Ceronio, 1999; Ntshona, 1999; Ullyatt, 1999; Van Dessel, 1999; Daki, 2001). However, the effects of these training programmes and their sustainability has not been clearly established. Furthermore, although past research has highlighted the difficulties associated with using untrained interpreters, it has almost been accepted as a fait accompli that trained interpreters are more effective than untrained interpreters in all aspects of the

interpreted interview. This has in fact not been proven, nor have there been direct comparison studies highlighting the areas of difference between trained and untrained interpreters in the health care setting. In accordance with this, a local review on interpreting in largely medical settings, highlighted the paucity of research on the variable impact of the interpreter's experience, qualifications and background on a medical interview (Wood, 1993). Therefore, it is proposed that there is a need for research examining the differences between trained and untrained interpreters, and thus the effectiveness of trained interpreters, since this might facilitate sustainability of interpreting services, as well as promote existing training programmes and allow for the establishment of additional interpreter training programmes. Furthermore, considering the current status and need for professionalisation of interpreters and the complexities of the interpreted interview, it is clear that there is a dire need for further research centred around training issues, relating to both the interpreter and the clinician in a health care setting.

Hence, the purpose of this study was to focus on the use of trained as well as untrained interpreters within an interpreted interview, with the hope that the findings from this study may contribute towards informing policy regarding the training of interpreters and clinicians and the implementation of more effective interpreting practices in health care.

The primary aim of this study was to document interpreted initial assessment interviews across trained and untrained interpreters within the field of Speech-Language and Hearing Therapy. This study aimed to not only identify and document mistranslations, but in line with recent shifts in research in the field of interpreting to identify and document patterns of accurate translations and possible reasons thereof. Furthermore acknowledging the complexities involved in an interpreted interview, this study aimed to investigate and document the communicative and interpersonal interactions between clients, clinicians and trained/untrained interpreters. Unlike past research this study focused on the perceptions of the clients, clinician and interpreters regarding informational content and interpersonal interactions.

As mentioned above, this study was conducted in the field of Speech-Language and Hearing Therapy. This field was selected as to the best of the researchers knowledge, besides research into sign-language interpreting (Akach & Morgan, 1999; Hertzog, 1999; Lotriet & Ceronio, 1999) little research has been conducted on the current state of

University of Cape Town

interpreting practices within the field of Speech-Language and Hearing Therapy. Despite this, the field of Speech- Language and Hearing Therapy has generally been ahead of other medical disciplines in the awareness for addressing the need for linguistic and cultural sensitivity to assessment and treatment (Battle, 1998; Wyatt, 1998; Penn, 2000; Penn & Friedland, in press). Hence, many speech-language and hearing therapists, have tended to adopt a more patient-centred approach to intervention. Thus it is surprising that the health profession most closely associated with language and communication has largely failed to adequately address the issue of interpreting within the field.

In this study, the researcher was motivated to explore the differences between untrained and trained interpreters using caregivers of hearing-impaired children as the untrained interpreters, since this has become a common clinical practice within the field. Within many of the disciplines allied to medicine there is little availability of nursing staff and hence the reliance on other patients or care givers of hearing-impaired children from the same clinics to fulfill the role of interpreters has become routine practice. Furthermore while most past research on 'ad hoc' interpreting practices has focused on the role of nurses, little has explored the role of other family members, patients or caregivers of children receiving rehabilitation.

The use of both quantitative and qualitative methods of analysis employed in this study, allowed for differences and similarities to be highlighted between the trained and untrained interpreters. Furthermore the use of qualitative methods of data collection and analysis allowed for an in-depth and rich reflection of all informants' perceptions.

Numerous theoretical and clinical implications may evolve from this study. Hopefully the findings of this study may have social benefit by impacting upon current clinical practices in interpreting in health care and informing future planning, training and policy. As Babbie (1995) suggests "*We can't solve our problems until we find out how they come about and persist. Social research offers a way of examining and understanding the operation of human social affairs,... and uncovering things that would usually escape our awareness, for the better of society as a whole*" (Babbie, 1995, p. xxii).

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Finally, it is believed that although some of the findings of this study may be specific to the field of Speech-Language and Hearing Therapy, many of them will be applicable across all fields within health care.

University of Cape Town

2. METHODOLOGY

This chapter presents the aims, research design, informant selection criteria and description of informants used in this study. In addition, methods of data collection and methods of analysis are described.

2.1 AIMS

The primary aim of this study was to identify and document the interpreted initial assessment interview across trained and untrained interpreters within the field of Speech-Language and Hearing Therapy.

More specifically:

- To identify patterns of mistranslations associated with the interpreted procedure in terms of type of mistranslations and cause of mistranslations across trained and untrained interpreters.
- To identify patterns of accurate translations and possible reasons therefore across trained and untrained interpreters.
- To investigate and document the communicative and interpersonal interactions between clients, clinician and trained/untrained interpreters within the assessment interview.
- To identify the roles adopted by the interpreters within the diagnostic interviews.
- To determine the perceptions of the clients, clinician and interpreters regarding informational content and interpersonal interactions.
- To develop guidelines for future training of clinicians and interpreters in the field of Speech-Language and Hearing Therapy.

2.2 RESEARCH DESIGN

An observational, descriptive, qualitative design was employed in this study. Qualitative methods enabled the researcher to study selected issues in detail. Qualitative research is effective when used on an exploratory basis to establish hypotheses for future research and

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when used to get an in-depth sense of what people think of a particular event, as there is space within this type of research structure to explore new information (Katzenellenbogen, Joubert & Yach, 1991). Thus, the methods used to obtain the necessary information enabled the researcher to gain access to the respondents views and experiences, expressed in their own words (Minichiello, Aroni, Timewell & Alexander, 1990). These methods were also useful for producing new ideas in areas which are new to research (Katzenellenbogen et al., 1991).

Qualitative research can be particularly effective when used simultaneously with other types of research to get additional perspectives on the problem (Katzenellenbogen et al., 1991). In using differing research methods as a means of addressing similar issues, findings are further confirmed and the information obtained is expanded (Krueger, 1994). Consequently the qualitative data from the semi-structured interviews with the participants has been used in conjunction with an error-analysis from the actual transcriptions of the initial assessment interview sessions. The triangulation of data by multiple methods was considered to be essential to answer many of the most important questions in organisational research, where there are a combination of very complex processes involving a number of factors over time (Cassell & Symon, 1997). Combined with observation, interviews allowed the researcher to understand the meanings people hold for their everyday activities (Marshall & Rossman, 1995).

University of Cape Town

2.3 INFORMANTS

The informants in this study consisted of three distinct categories. The first category consisted of the clinician involved in the assessment interviews. The second category consisted of the three trained and three untrained interpreters who were employed in the assessment interview sessions. The third category consisted of the primary caregivers of the hard of hearing or deaf children who took part in the speech and hearing therapy programme used in this study.

A total of *six initial assessment interviews* and *18 post-session interviews* were included in the study. Details of the procedure adopted are provided in Section 2.4.

2.3.1 Selection Criteria

The following criteria were applied in the process of informant selection:

2.3.1.1 Clinician

The clinician was required:

- To be a qualified Speech-Language and Hearing Therapist (i.e. BSc Communication Sciences and Disorders)
- To be first language (L1) English-speaking
- To be experienced in the field of Speech-Language and Hearing Therapy

2.3.1.2 Interpreters

a) The trained interpreters were required:

- To be L1 Xhosa-speakers
- To be proficient speakers of English
- To be an integral part of the Xhosa-speaking community of the Western Cape
- To be culturally similar to Xhosa-speakers from the Western Cape
- To have attended a formal interpreter training programme and to have had some previous exposure to the field of Speech-Language and Hearing Therapy.

b) The untrained interpreters were required:

- To be L1 Xhosa speakers
- To be proficient speakers of English
- To be an integral part of the Xhosa-speaking community of the Western Cape
- To be culturally similar to Xhosa-speakers from the Western Cape

University of Cape Town

2.3.1.3 Caregivers

Caregivers were required:

- To be the primary caregiver of a hearing-impaired child
- To be a Xhosa L1 speaker with insufficient knowledge of English to allow them to communicate effectively in English in a clinical consultation

2.3.2 Informant Description

2.3.2.1 Clinician

The clinician who took part in this research will hereafter be referred to as Cl. Biographical details pertaining to Cl. are presented in Table 2.1 below.

University of Cape Town

Table 2.1: Biographical Details of the Clinician (Cl.)

First Language	English
Other Languages	Afrikaans, Xhosa
Proficiency in Xhosa	Very basic
Medium of Instruction at School	English
Training Regarding Interpreters	Module in Psychology III course
Job Description	Clinician in a community-based speech and hearing service
Years of Experience in this Field	2.6 years
Frequency of Working with Interpreters	Once-twice per week

2.3.2.2 Interpreters

Three trained interpreters were employed in this study. Hereafter, they will be referred to as TI1, TI2 and TI3. Three untrained interpreters participated in this study and will hereafter be referred to as UI1, UI2 and UI3. Biographical details pertaining to the trained and untrained interpreters are presented in Table 2.2 and 2.3, respectively.

Table 2.2: Biographical Details of the Trained Interpreters (TI1, TI2, TI3)

	TI1	TI2	TI3
Residential Area	Gugulethu	Gugulethu	Mitchells Plein
First Language	Xhosa	Xhosa, Sotho	Xhosa
Other Languages	English, Zulu	English, Sotho, Afrikaans	English, Afrikaans, Sotho
Proficiency in English	Good	Good	Good
Medium of Instruction at School	Xhosa (primary) English (secondary)	Xhosa (primary) English (secondary)	Xhosa (primary) English (secondary)
Education Level	Grade 12	Grade 12	Grade 11
Other Qualifications	Aids awareness course, sign language course	Research assistant, Aids awareness course	Computer course
Training	Formal training programme	Formal training programme	Formal training programme
Length of Training Course	6 months	6 months	6 months
Year of Graduation	1996	1997	1997
Training in the Field of Speech-Language & Hearing Therapy	None	None	None
Job Description	Interpreter	Interpreter	Interpreter
Experience in this Job	Four years	Five years	Two years

Table 2.3: Biographical Details of the Untrained Interpreters (UI1, UI2, UI3)

	UI1	UI2	UI3
Residential Area	Khayelitsha	Khayelitsha	Khayelitsha
First Language	Xhosa	Xhosa	Xhosa
Other Languages	English	English	English, Afrikaans, Zulu
Proficiency in English	Good	Good	Good
Medium of Instruction at School	Xhosa (primary) English (secondary)	Xhosa (primary) English (secondary)	Xhosa (primary) English (secondary)
Education Level	Grade 12	Grade 11	Grade 10
Other Qualifications	Computer course	Computer course	First aid course
Training	None	None	None
Employment	Till packer	Unemployed	Unemployed
Previous Experience Interpreting	None	None	None

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As can be seen in Table 2.2 and 2.3, all the trained and untrained interpreters appeared to have similar levels of proficiency in English. Determination of English proficiency was considered very carefully and involved a number of stages. Initial proficiency in English was determined by engaging in conversation for a lengthy period of time about topics such as their proficiency in English, as well as interpreting experience and biographical information. Following this, questions adapted from Paradis' (1987) English History Questionnaire were directed at the possible informants. The questions regarded their use of English, for example when it was acquired, their exposure to the English language as children (in both home and school environments), their use of the English language in adulthood, etc. On this basis, a subjective assessment of their English proficiency was made, and if their English skills were thought to be adequate, they were included in the study. Thus, the researcher made every attempt to determine the frequency of use and proficiency in English of the interpreters selected for this study. To the best of the researcher's knowledge, the English proficiency of the interpreters selected for this study was considered adequate for the purposes of this research.

All interpreters, trained and untrained, had received secondary education, with a minimum level of Grade 10. The trained interpreters had all received the same amount of training in interpreting practices, in the same formal training programme. Although none of them had undergone any field specific training, they all had some previous exposure to the field of Speech-Language and Hearing Therapy.

Furthermore, all untrained interpreters were selected from the waiting room areas of the centre and community-based rehabilitation programmes, and thus were caregivers of hearing impaired children. This was considered as being optimal since patients in the waiting room are routinely called upon to offer interpreting services in clinical practice.

2.3.2.3 Caregivers

The six caregivers who took part in the assessment interview sessions will hereafter be referred to as C1, C2, C3, C4, C5 and C6. Biographical details pertaining to the caregivers are presented in Table 2.4.

University of Cape Town

Table 2.4: Biographical Details of the Caregivers (C1-C6)

	C1	C2	C3	C4	C5	C6
First Language	Xhosa	Xhosa	Xhosa	Xhosa	Xhosa	Xhosa
Other Languages	English	English	English	English	English	English
Proficiency in English	Poor	Poor	Poor	Poor	Poor	Poor
Medium of Instruction at School	Xhosa + English	Xhosa + English	Xhosa + English	Xhosa + English	Xhosa + English	Xhosa + English
Education Level	Grade 10	Grade 10	Grade 9	Grade 7	Grade 7	Grade 8
Employment	Till packer	Char	U/E	U/E	U/E	U/E
Relation of Caregiver to Child	Mother	Mother	Mother	Mother	Mother	Mother
Age of the Child	5 years	9 years	3 years	9 years	3 years	9 years
Hearing Status of the Child	Moderate-severe SNHL bilat.	CHL bilat.	Moderate-severe, sloping SNHL bilat.	Mild, low frequency CHL bilat.	Moderate CHL unilat.	SNHL bilat.
Age of Onset of Hearing Loss (HL)	Birth	First year	Birth	Recent	Intermittent since 2 years	First 3 years
Presence of Other Difficulties	Delayed speech	Familial abuse	Global delay	None	None	Mild global delay

Key: CHL – Conductive Hearing Loss; SNHL – Sensorineural Hearing Loss; U/E – Unemployed; Unilat. – Unilaterally; Bilat. – Bilaterally

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As can be seen in Table 2.4, all of the caregivers in this study were mothers of hearing impaired children with little or no skills in either English or Afrikaans. Furthermore, some of the children presented with additional difficulties, besides speech-language and hearing disorders.

2.3.2.4 Description of Programmes

This research was conducted at two sites, namely a centre-based and a community-based speech and hearing therapy programme. Below, an explanation of the speech and hearing therapy and interpreter programmes that impacted on the context of this study is provided.

i) Centre-based Speech and Hearing Therapy Programme

The primary aim of the centre-based speech and hearing therapy programme is to provide comprehensive intervention for hard of hearing and deaf children in the Western Cape. This service provides appropriate, holistic, multidisciplinary intervention and rehabilitation for these children, within a tertiary health care institution. An interpreter (TI3) is employed once a week at the centre.

ii) Community-based Speech and Hearing Therapy Programme

The community-based speech and hearing therapy service is a community-based component of the centre mentioned above. It was initiated in response to the two primary barriers to intervention of the hearing impaired child in the Western Cape, namely finance and accessibility. Thus the focus of this community-based programme is on the early identification of hearing disorders as well as intervention with hard of hearing and deaf children, in disadvantaged communities throughout the province. The programme offers the following comprehensive services at a primary and secondary health care level: hearing screening; identification of middle ear infections; diagnostic hearing testing; hearing aid fittings and evaluations; counselling; school placement; education of professionals involved in the detection of hearing impairment; creating greater public awareness of hearing impairment; and training programmes for caregivers and teachers of hard of hearing children.

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Three audiologists are employed to work on this programme and an interpreter (TI3) is employed once per week in the provision of the service within the Cape Metropole region of the province. The majority of Xhosa-speaking patients seen by the community-based programme are seen at health facilities in this area.

iii) Interpreter Training Programme

TI1, TI2 and TI3 were formally trained in an interpreter training programme, run by a non-governmental organisation based in Cape Town (Ntshona, 1999). The organisation's aim is to facilitate the access of linguistically marginalised Xhosa-speaking patients to health care services, while at the same time creating career and job opportunities for individuals

from disadvantaged backgrounds. The project was initially funded by the Flemish government in 1997 under the premise that the Western Cape provincial authorities would take over the employment of these interpreters, after a period of two to three years. However, this has not happened, primarily as a result of financial constraints and lack of awareness of the need for interpreters.

In 1997, two groups of students were trained within this interpreter training programme. In total, 22 students have completed the course. The students completed one month of theory and one month of practical courses (Ntshona, 1999). The curriculum was designed by a focus group consisting of a multi-disciplinary team of university lecturers, parliamentarians, doctors and human rights activists. The theoretical course comprised of lectures, group discussions, case studies and role-play of interpreted situations. The modules covered in the theory components are presented in Table 2.5 below. The practical course involved a one-month placement in a hospital under the supervision of the course co-ordinators (Ntshona, 1999). Evaluation was conducted at the end of each day, with a test at the end of the first month and an exam at the end of the second month. Certification was issued to successful candidates at the end of the course (Ntshona, 1999). A comprehensive list of the objectives of the programme and the course curriculum can be found in Ntshona (1999).

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Table 2.5: Components of the Interpreter Training Programme (Ntshona, 1999)

Interpreting: 1 week
Counselling and Cultural Issues: 1 week
Skills Development: 1 week
Health Information including Health Promotion: 1 week
Ethical Issues: ½ day
Administration: 1 day
Constitutional Affairs: ½ day

2.3.2.5 Job Description of the Community Interpreter

All three trained interpreters used in this research were trained to be community interpreters. Sanders (1996 in Ntshona, 1999) describes community interpreting as playing a five-fold role which encompasses advocacy, empowerment, the transmission of information to patients and service providers, communication support and networking.

Their summarised job description stipulates that they are to facilitate communication between Xhosa-speaking patients and non-Xhosa-speaking health care providers, by offering interpreting services and ensuring that the Xhosa-speaking patients obtain appropriate health care and service. The principle duties of the interpreter as stipulated by their job description (see Appendix C), include cultural brokerage as well as patient advocacy (Ntshona, 1999). Cultural brokers fulfil their function by explaining and clarifying the cultural context and the indigenous beliefs of particular patients (Drennan, 1998). Furthermore, a cultural broker can assist the clinician in assessing whether or not the patient's beliefs are in keeping with the group from which he or she comes (Swartz, 1998). Patient advocacy is considered necessary for patients with difference cultures and languages than the professionals that are assisting them (Drennan, 1998).

2.3.2.6 Informed Consent

Agreement of the clinician, caregivers as well as trained and untrained interpreters to participate in the research was obtained via verbal and written consent. The purpose of the study as well as the procedures to be undertaken were fully explained to all informants involved in this research. Anonymity of the informants was guaranteed throughout the research project.

2.3.3 Pilot Study

A pilot study was carried out with one clinician, one interpreter (TI3) and one caregiver at the centre-based speech and hearing therapy programme. The aims of this pilot study were as follows:

- To estimate the time required for each initial assessment interview.

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- To measure the effectiveness and appropriateness of the open and closed-ended questions that were developed for the initial assessment interview.
- To observe the type of group dynamics one could expect from an initial assessment interview.
- To identify any technical difficulties that might arise from the video-recording, seating arrangements and the sound quality.

Based on the pilot study, the following was determined:

- The analysis would need to be data driven in order for all relevant data to be included in the analysis.
- Although the Mistranslation Analysis Tool (Evans, 2000) was likely to be an effective means of identifying and examining mistranslations across trained and untrained interpreters, modifications would be necessary due to the differing research focus in this study.
- An observational analysis would be needed to evaluate the non-verbal behaviours of the interpreters, as well as how they impacted on the initial assessment interview.

Data from the pilot study was not included in the research project.

University of Cape Town

2.4 DATA COLLECTION: PROCEDURE AND MATERIALS

The data collected in this research project consisted of two main components, namely:

- Recording of initial assessment interviews
- Conducting and recording of individual post-session interviews

All informants took part in one of the six recorded initial assessment interviews. Thereafter, each informant was interviewed, to obtain their impressions of the interpreted interview specifically, as well as interpreting experiences in general. Eighteen post-session interviews were individually conducted by the researcher with the clinician, the trained/untrained interpreter and finally the caregiver involved in the specific initial assessment interview. An assistant interpreter (hereafter referred to as participant interpreter

- PI) was employed to interpret for the caregiver and the researcher in the post-session interviews with the caregivers. The process of data collection is represented in Figure 1.

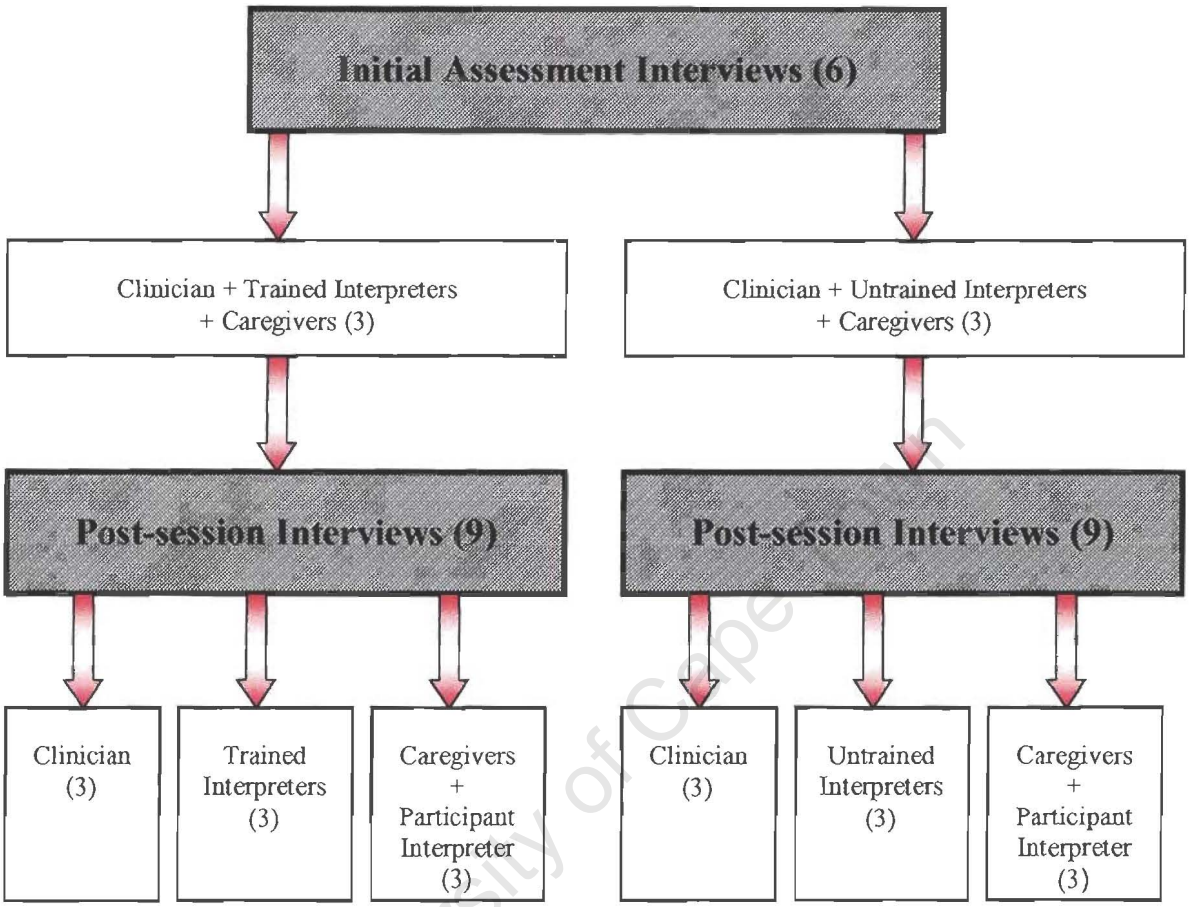

Figure 1: The Data Collection Procedure

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2.4.1 Procedure

This section examines the procedure in terms of setting, timing and equipment used.

2.4.1.1 Setting

i) Initial Assessment Interview Setting

The initial assessment interviews were conducted at the centre-based, as well as the community-based rehabilitation sites.

ii) Post-session Interview Setting

All caregiver, interpreter and clinician post-session interviews were recorded at the respective sites where the initial assessment interviews had been conducted. Post-session interviews were conducted immediately after the initial assessment interviews. This is in accordance with Katzenellenbogen et al. (1991), who suggest that qualitative research needs to be carried out in as naturalistic environment as possible as this shows acknowledgement of the influence that the situation has on behaviour and that behaviour has on situations (Cassell & Symon, 1997). Attention was also paid to Lutz et al.'s (1992) recommendations that interviews should preferably be conducted with the respondent alone, in a place of reasonable comfort and away from disturbance.

2.4.1.2 Time

The length of the initial assessment interviews ranged from 20-30 minutes, while the length of the post-session interviews ranged from 15-20 minutes. In total, nine hours of interview material were recorded.

2.4.1.3 Interview Recording and Equipment

All sessions and interviews were recorded on to videotape. This method was selected as opposed to audiotape as the additional visual cues provided by video-recording would assist in the transcription process, particularly when considering that the informants were from varying cultures. In addition, video-recording was essential to allow for examination of non-verbal behaviours of the informants.

2.4.2 Materials

It was necessary to administer a set of questions for the initial assessment interviews and to construct a set of questionnaires as a basis for the semi-structured post-interview sessions.

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2.4.2.1 The Initial Assessment Interview Questions

The initial assessment interview included the following components:

- Closed-ended/specific questions for more factual information
- Open-ended/general questions to obtain more opinionated or emotional responses from the caregivers.

The specific closed-ended questions were based on those from a traditional case history form (Ehrlich, 1985) and related to biographical information, language information, and hearing history of the children concerned.

Although closed-ended questions familiar to a bio-medical approach were used, the clinician having had training in Speech-Language and Hearing Therapy, had exposure to the use of culturally sensitive techniques, and accordingly a number of open-ended questions were included in the initial assessment interview. Thus, the initial assessment interview conducted by the clinician was composed of closed as well as open-ended questions, as was characteristic of her usual manner of conducting an initial assessment interview. Penn (2000) stated that the subjective experiences of clients are often overlooked in clinical interactions with the use of traditional case history practices, in the search for objective indices of severity and prognosis. The use of open-ended questions was an attempt to address Penn's observation. Examples of some of the open-ended questions used in this study are "Tell me all about your child's problem" and "What do you think caused your child's problem?".

At times, feedback of the audiological assessment, as well as discussion of rehabilitation options and counselling was included within the initial assessment interviews. However, this was often not necessary and thus all of the initial assessment interviews were not characterised by discussion of these aspects.

2.4.2.2 Construction of the Questionnaires for the Post-interview Sessions

Questionnaires were developed as a basis for the semi-structured post-interview sessions with the clinician, the caregivers, as well as the trained and untrained interpreters.

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Questions were based on a number of central themes which were loosely guided by relevant topics that had emerged from the literature on interpreting, however additional themes were added which were felt to be relevant to this particular study.

Table 2.6: Themes Included in the Questionnaires

Biographical information with a special focus on language information, training and experience with interpreting or using interpreters
Accuracy of interpreting
The interpersonal dynamics that impacted on the clinical encounters
Satisfaction with quality of service offered to speakers of indigenous languages
Cultural factors which impacted on the clinical encounters

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i) Principles Underlying the Construction of the Post-interview Questionnaires

a) Semi-structured vs Unstructured Interviewing

All interviews were conducted in a semi-structured manner, that is they followed the well-defined structure of the questionnaires, but allowed for deviation from these questionnaires for varying clarification techniques and additional questioning where necessary. A certain degree of systematicisation in questioning is said to be indicated when many informants are interviewed (Marshall & Rossman, 1995).

This means of data collection was chosen above a self-administered questionnaire to avoid the problem of poor literacy skills. Furthermore, a self-administered questionnaire would not have allowed the researcher to ask for further clarification on issues and would have restricted the amount of information obtained.

In addition, the employment of a semi-structured interviewing method allowed the researcher to partially control the length of the interviews, thereby limiting the length of the transcription. Considering that Skinner and van der Walt (1994 in Joubert et al., 1997) have indicated that an hour long interview can take up to eight hours to transcribe, limiting the length was a significant factor, bearing in mind the time constraints.

Swartz (1998) mentioned that an interpreted interviews can be time consuming and may be awkward to manage. Consequently, careful planning is needed to ensure that the process is conducted as smoothly and efficiently as possible. A semi-structured interview allowed a *participant interpreter* (PI) to translate the English questions into Xhosa prior to the data collection. The PI was an interpreter who was selected specifically to conduct the post-interviews with the Xhosa-speaking caregivers. Thus, semi-structured interviews gave the PI the opportunity to ask for clarification about terminology that he did not understand.

Finally, a semi-structured interview was chosen above an unstructured interview, since an unstructured interview was thought to be beyond the scope of this study. This is due to the fact that the interviewer who directs such an interview requires much skill and experience in interviewing in order to avoid poor reliability as a result of increased subjectivity (Joubert, Karim & Katzenellenbogen, 1997).

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b) Types of Questions

The questionnaires were developed using the guidelines proposed by Joubert and Katzenellenbogen (in Joubert et al., 1997). The questionnaires consisted of both open and closed-ended questions. The majority of the questions used in the semi-structured interview comprised open-ended questions which enabled the researcher to capture and understand the points of view of other people without predetermining those points of view through prior selection of questionnaire categories (Patton, 1990). Open-ended questions also enabled the researcher to obtain more opinionated and emotional responses from the informants. Closed-ended questions requiring a "yes" or "no" answer or a response limited in alternatives, were fewer in number and were used with the objective of obtaining more factual information (e.g. biographical details).

c) Phrasing of Questions

Questions were phrased in such a way that they would be concise, unambiguous and easy to translate into Xhosa. The language level of the questions did not require the caregiver to have a high level of sophistication and the questions were simple enough for the PI to be able to translate them with ease. Sentences were short and concise, considering that it has

been previously shown that decreasing sentence length increases the chance of the utterance being accurately translated (Launer, 1978; Bal, 1981; Vasquez & Javier, 1991; Evans, 2000).

d) Language of Questionnaires

The interpreters and the clinician responded to the questionnaires in English as they all felt competent speaking English and in addition, this prevented the researcher from having to use an interpreter. As mentioned above, considering that the caregivers were not competent in English, a participant interpreter was employed to interpret for the caregivers' post-session interviews.

e) Minimising the Interpreter Effect

The fact that the researcher was unable to communicate effectively with the caregivers in their own language was problematic, considering that one of the aims of the study was to document the perceptions of Xhosa-speaking caregivers in an interpreted assessment interview. As a result of this, an additional interpreter (PI) was needed for the post-interviews with the caregivers. However, this was anticipated as being problematic due to the reported inaccuracy of interpreted interviews, particularly when the interpreter is untrained (Vasquez & Javier, 1991; Wood, 1993; Crawford, 1994; Drennan, 1998; Bowen, 2000).

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Several authors have recommend a number of techniques to minimise the negative effects of interpreters (Marcos, 1979; Lutz, Chalmers, Lockerbie & Hepburn, 1992; Wood, 1993; Swartz, 1998; and Evans, 2000). Based on these recommendations, a number of stringent procedures were followed to eliminate the negative effects of an interpreted interview.

These strategies included:

- The researcher selected the PI based on criteria of language proficiency, knowledge of the caregiver's culture and knowledge of Speech-Language and Hearing Therapy.
- After selecting the PI, the interpreter received training. This training involved an explanation of the aims of the research project and the goals of the training, the

recognition of the problems of an interpreted interview and the anticipation of problems that could arise in the interview sessions. Concepts that would need explaining to the PI were chosen according to the relevance, frequency of use and the themes under investigation. The components of PI's training, based on the recommendations of Lutz, et al (1992), and Evans (2000) are summarised in Table 2.7.

Table 2.7: Components of the Participant Interpreter's Training

The purposes and objectives of the research
The interpreter's duties and responsibilities
Explanation of the interviewing procedure
Training the interpreter to ask the questions and conduct the actual interview
Troubleshooting of potential difficulties

- In accordance with Lutz et al.'s (1992) suggestions, teaching materials were provided to the PI for his perusal prior to the training session. The materials consisted of:

  - A short, simple summary of the study including the aims and objectives as well as a description of the population and the community and the other people involved in the research. This included a copy of the questions to be asked.
  - Brief notes outlining how the PI should conduct himself.
  - Trouble-shooting issues which might arise.

- Once the training was complete, the PI was prepared for interpreting the semi-structured interviews. During the recording of the post-interview sessions with the caregivers, the following were implemented in order to ensure that the interpreting was as accurate as possible:

  - The PI was introduced to the caregiver and provided her with an explanation of who was involved in the study and encouraged the caregiver to ask any questions regarding the research.
  - The researcher encouraged both the PI and the caregiver to ask for clarification on any issues.

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- The researcher attempted to use appropriate strategies for the elicitation of accurate interpretation, including short, simple questions; repetition and rephrasing of questions when necessary.
- The researcher made note of non-verbal cues.

- Following the recorded interviews, the researcher and PI would briefly discuss the following issues in post-recording meetings:

  - Problems which had arisen
  - Cultural issues which may have arisen
  - The content of the caregiver's responses
  - Group dynamics
  - Accuracy of information and the use of strategies such as clarification

ii) Participant Interpreter (PI):

The PI is a 23 year old male student who is a Xhosa L1 speaker and who is currently a final year Speech-Language and Hearing Therapy student at a local university. The PI also attended an English-speaking high school.

2.5 TREATMENT OF DATA

2.5.1 Transcription of Raw Data

Each initial assessment interview and post-session interview was transcribed verbatim from the video recordings. Verbatim transcriptions were deemed necessary in order to allow a detailed analysis to be carried out (Patton, 1990). All Xhosa interviews were transcribed by Xhosa L1 speakers, and all the post-session interviews conducted in English were transcribed by the researcher. This was considered to be a major advantage because it allowed the researcher to become familiar with much of the data and at the same time allowed for the process of data analysis to begin (Minichiello et al., 1990). In total 32 hours of English transcription and 30 hours of Xhosa transcription were conducted.

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Selection criteria for the transcribers of the Xhosa dialogue were as follows:

- Xhosa L1 speaker
- University graduate/student

2.5.2 Translation of Raw Data

The transcribed Xhosa transcripts were translated into English by translators. In total, 24 hours of translation from Xhosa to English were carried out.

Selection criteria for the translators were:

- Xhosa L1 speaker
- University graduate/student

2.6 ANALYSIS OF THE DATA

The data from the transcribed dialogue in the recorded initial assessment interviews, was analysed using the revised version of the original Mistranslation Analysis Tool (Evans, 2000). The data from the semi-structured post-interviews was analysed using a thematic analysis.

2.6.1 Analysis of the Transcribed Data from the Initial Assessment Interviews

Following the recommendations of the Pilot Study (Section 2.3.4), it was decided that the Mistranslation Analysis Tool (MAT) devised by Evans (2000) was suitable for analysing the accuracy of the interpreted discourse. However, certain modifications were made according to the purposes of this study[6].

[6] The researcher has been given permission to use and modify the original MAT, developed by Evans (2000). Forthwith, the MAT will be referred to as the revised MAT, in line with the modifications made to the original version.

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2.6.1.1 Description of the Revised MAT

The original MAT (Evans, 2000) provided a means of systematically evaluating the positive and negative contributions of the interpreter mistranslations within the discourse. In order to be able to evaluate the contribution of the interpreter, any exact translations, that is any instances in which the interpreter was acting purely as a linguist (Swartz, 1998), were eliminated so that only mistranslations were analysed. Thus, a large proportion of the utterances which were accurately translated, were not examined by the original MAT (Evans, 2000), since these were all considered to be positive.

However, as one of the aims in this study was to examine the accurate translations for the purposes of developing training guidelines for clinicians and interpreters, the mistranslations as well as the accurate translations were examined for possible causes in this study. The researcher came up with a preliminary list of reasons for accurate utterances, since this was thought to be of use for interpreter and clinician training guidelines. The accurate utterances were also counted so that comparison could be made between the amount of accurate and the amount of inaccurate utterances within an interpreted interview. In addition to this, the neutral mistranslations (see Section 2.6.2.3) were eliminated from all transcripts and did not form part of the analysed data. They were considered to have no effect on the accuracy or inaccuracy of the interpreted interview, and as a result, were eliminated.

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The following terminology needs to be defined for the purpose of this analysis:

- Original utterance (O): This is the utterance which was spoken by either the caregiver or the clinician and which required translating in order to be understood by the other person.

- Translated utterance (T): This is the utterance spoken by the interpreter following an original utterance.

- Proposition: A proposition was defined as a part of an utterance which contains one, and only one main idea. For the purpose of this research, the proposition was the unit of analysis.

- Mistranslation: A mistranslation of a proposition can be said to have occurred when the original utterance and the translated utterance are not identical. In order to ascertain whether or not a mistranslation has been made, the information contained in O needs to be compared to that contained in T. If an accurate translation has been made, T will be exhaustive in that it will contain all the information contained in O, and limited in that it will contain only the information contained in O. If a translation is not accurate, a mistranslation can be said to have occurred.

By systematically analysing the original and the translated data to find out where exact translations had taken place, the researcher is on one level acknowledging the principles of the empiricist approach, which views the process of interpreting as swopping the labels for words in one language to the same labels but in another language (Swartz, 1998). The researcher is thus identifying when the interpreter did not follow such an approach. However, because this tool takes the mistranslations one step further, and examines whether or not the mistranslations were helpful or unhelpful, the researcher is acknowledging the potential positive and negative contributions that an interpreter can make. This latter step is consistent with the hermeneutic approach, which recognizes that translation is a complicated process and does not simply involve changing labels from one language to another (Swartz, 1998).

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2.6.1.2 Components of the Revised MAT

The main components of the revised MAT are as follows:

- Contribution: All mistranslations were analysed according to the type of contribution that they made. Mistranslations were designated to making either a positive, negative or neutral contribution. As mentioned previously, for the purposes of this study, the neutral utterances were eliminated.

- Type of error: A review of the literature indicated five types of mistranslations, namely: omissions, additions, initiation of questions, condensation and substitution (Vasquez & Javier, 1991; Wood, 1993; Drennan, 1998; Swartz, 1998). As the focus of this study was not an in-depth examination of the types of mistranslations, the types of mistranslations were reduced to additions (which included initiation of

questions, as well as additions as a result of substitutions) and omissions (which included condensation, as well as omissions as a result of substitutions) for the purposes of this study.

- Reason for mistranslation: A review of the literature (Sabin, 1975; Marcos, 1979; Ebden, Carey, Bhatt & Harrison, 1988; Wood, 1993; Swartz, 1998) identified a number of factors which were considered to result in mistranslations. Evans (2000) grouped these reasons within the broad categories of positive, negative or neutral, which could be further divided into the following:

  - Positive due to a) attempts to increase understanding
    b) attempts to facilitate cultural brokerage

  - Negative due to a) textual factors: the nature of the text (e.g. length, difficulty of words or concepts)
    b) non-textual factors: external factors such as the interpreter's attitude or abilities resulted in the mistranslations

  - Neutral due to a) the presence of non-content information
    b) the fact that no translation was required

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It should be noted that decisions that involved the researcher making a judgement on cause (reason for mistranslation) and even more so on effect (contribution), were subjective decisions. It should also be noted that within this field of interpreting, it is very difficult to make an objective decision. According to Penn (2000), there should be acknowledgement that research on interpreting issues can really never be empirical or neutral as relationships of power, historical influences and a whole history of labelling within the profession needs to be taken into account. Considering these factors, ensuring reliability of results entailed the use of a number of procedures, which are discussed in Section 2.7.

2.6.1.3 Definitions of the Components of the Revised MAT

i) Contribution of the Mistranslation

Mistranslations were considered to be *positive* if they made a helpful contribution to the discourse; *negative* if they were unhelpful or rendered the discourse confusing; or *neutral* if it was felt that they made no significant contribution to the outcome of the discourse.

ii) Type of Mistranslation

- Addition: This occurred when the interpreter added to what the speaker had said (Vasquez & Javier, 1991; Swartz, 1998). In this study, additions also incorporated initiation of a question and substitutions. Initiation of a question occurred when the interpreter added a question which had not been asked by the speaker (Wood, 1993). This was differentiated from an addition by virtue of the fact that initiation of a question had to be a question specifically, and the reasons for asking each of them appeared to be very different. This is referred to as *role exchange* by Swartz (1998) because when the interpreter initiates a question, she is exchanging roles with the clinician. Substitution occurred when the interpreter replaced something that had been said with something that had not been said (Swartz, 1998). It incorporates elements of both addition and omission.

- Omission: This occurred when the interpreter left out part or all of what the speaker said (Vasquez & Javier, 1991; Swartz, 1998). Omissions in this study included condensations and substitutions. Condensation occurred when the interpreter summarised what had been said according to their own view (Swartz, 1998). It incorporates elements of both omission and substitution. However, condensation differs from omission in that information is not left out altogether, but simplified so that the basic framework remains. Condensation also differs from substitution in that it implies a shortening of length whereas a substitution does not suggest this.

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iii) Reason for the Mistranslation

- Cultural brokerage: Examples of facilitating cultural brokerage include the use of more culturally appropriate terminology, the provision of analogies, modification of original lengthy utterances, the use of a euphemism or hyperbole as a more appropriate way of illustrating a point, the use of repetition for effect and the use of praise as a means of providing encouragement.

- Increased understanding: Interpreters often have to simplify some of what the clinician says in order for concepts to be more accessible to the patient. The ways in which the interpreter could achieve this are explanation of a concept (cause and effect necessary for something to be considered an explanation), expansion of the topic (extension of an already-mentioned point, must involve the addition of new information), repetition, summary of a lengthy utterance (Wood, 1993), checking on the caregiver's or clinician's feelings about an issue and seeking clarification.

- Textual information: Factors which are considered to be inherent in the text include the use of difficult anatomical or medical terminology (Ebden et al., 1988) or lack of word equivalents (Swartz, 1998), technological terminology (Ebden et al., 1988), difficult concepts (Wood, 1993), use of words with connotative meaning (words which hold associations or intentions) as opposed to denotative meaning (which refers to the actual definition of the word), lengthy original utterances (Wood, 1993), summary, emotive words (Sabin, 1975 in Wood, 1993), reassurance, expansion, illustration with an example, explanation, questions and instructions.

- Non-textual information: Factors which were considered to be external contributors to mistranslations include selective interpretation, 'showing off' or the interpreter attempting to demonstrate her own medical acumen (Wood, 1993), cultural brokerage, poor language or translational skills (Marcos, 1979), lower level of sophistication in that field (Marcos, 1979 in Wood), poor attitude (Marcos, 1979), interpreter frustration or irritation (Swartz, 1998), outside distractions, fabrications, misinterpretation and interpreter acting as interviewer. The last three reasons for non-textual mistranslations were modifications made to the original MAT (Evans, 2000) by the researcher.

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- Non-content information: This included information which was the clinician's or caregiver's confirmation or clarification of what had been previously said (often manifested as the repetition of the last few words uttered by the interpreter), conversation fillers or thinking aloud, administrative instructions, prompts by the clinician or the caregiver to the interpreter, poor sound quality on the recording, translated language used by the clinician or the caregiver (when the clinician spoke in Xhosa or the caregiver answered in English), corrections, communication within groups (the clinician communicating with students or the caregiver communicating with her children), checking on an interpretation and thanks or praise directed at the interpreter. It was felt that none of these, when added or omitted contributed either positively or negatively to the interaction.

- Translation not required: The following were considered not to need a translation to be fully understood - yes/no exclamations, gestures, simple propositions (e.g. "andiyaz", "esikolweni:", "what is your name?"), simple propositions containing a personal pronoun or a number (e.g. "nguMandy igama lam", "Khayelitsha, Block B"), questions directed to the interpreter from the clinician or the caregiver and answers to such questions. The reader is reminded that both non-content information and information that did not require a translation were eliminated and not analysed in this study.

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2.6.1.4 Layout of the Revised MAT

The original MAT (Evans, 2000) was designed on a grid format in Excel. On the Y-axis, the researcher divided the rows into positive, negative and neutral and then further divided these into the broad categories and then the specific reasons for why the mistranslations had been made. On the X-axis, the researcher positioned the five types of errors. In this study, the revised MAT does not include the neutral mistranslations on the Y-axis, and the types of errors were collapsed into additions and omissions on the X-axis. Figure 2 illustrates the format of the revised MAT.

			Addition	Omission
Positive	Cultural Brokerage	More culturally appropriate		
		Analogy/example		
		Lengthy original utterance		
		Euphemism		
		Hyperbole/emphasis		
		Repetition for emphasis		
		Praise/encouragement		
	Increase Understanding	Explanation		
		Expansion		
		Repetition/reinforcement		
		Summary		
		Checks Cg's or Cl's understanding		
		Clarification		
		Accurately repeats what was said		
Negative	Textual	Anatomical/medical terminology		
		Difficult terminology		
		Difficult concept		
		Connotative word		
		Lengthy original utterance		
		Summary		
		Emotive		
		Praise/encouragement		
		Expansion of previous utterance		
		Example		
		Explanation		
		Questions		
		Instructions		
	Non-textual	Selective interpretation		
		Demonstration of medical acumen		
		Interpreter fatigue		
		Interpreter frustration		
		Cultural brokerage		
		Poor language skills		
		Lower level of sophistication		
		Poor attitude		
		Outside distraction		
		Fabrication		
		Misinterpretation		
		Interpreter as interviewer		

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Figure 2: The Revised Mistranslation Analysis Tool

2.6.1.5 Procedure for Analysing Data from the Revised MAT

The procedure for analysing the accuracy of the trained and untrained interpreters, involved four stages of analysis. Figure 3 below depicts the revised MAT analysis procedure. See Appendix D for an excerpt of a coded transcript.

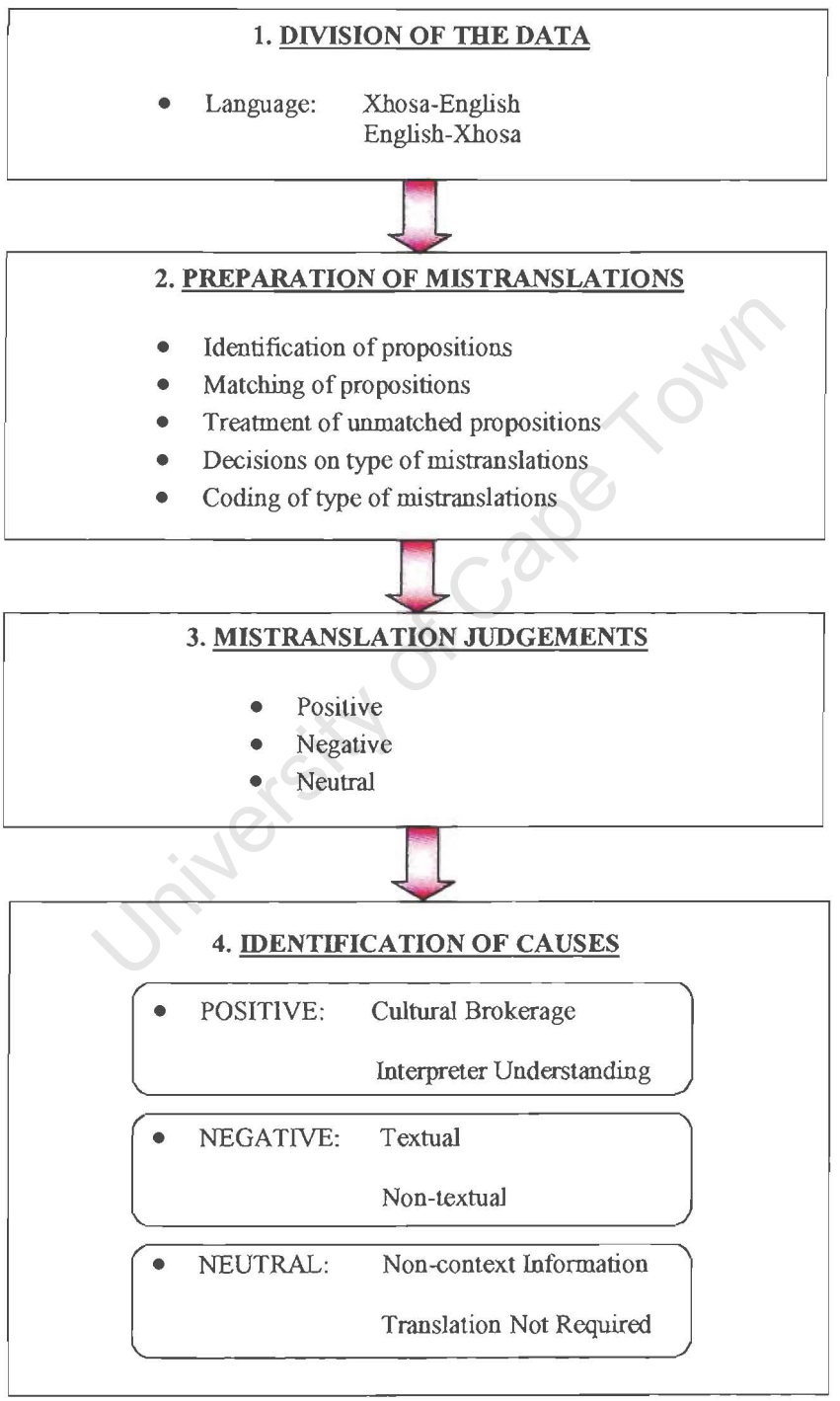

Figure 3: Flow Diagram Depicting the Revised MAT Analysis Procedure

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Stage One: Division of the Data

In the first stage, the data was divided into manageable portions. This involved dividing the data into English-Xhosa and Xhosa-English to allow for later comparison of whether the interpreter differed in her ability to translate in either direction.

Stage Two: Preparation of Mistranslations

In the second stage, the data was prepared for the mistranslation analysis. This involved dividing the data into propositions and matching those propositions that were identical. Propositions were said to match if the translated utterance (T) contained all that was contained in the original utterance (O) and nothing more than what was contained in O. Matched propositions were crossed out and eliminated from the mistranslation analysis, and thus formed part of the accurate translations. The remaining propositions therefore consisted of mistranslations that were ready for analysis. The propositions were then coded according to type of error made. Additions and omissions were coded using the letters A and O, respectively.

Stage Three: Judgements of Mistranslations

In the third stage, each error was individually analysed according to whether it was considered to be making a positive, negative or neutral contribution. Positive, negative and neutral were indicated using + , - , and | signs, respectively.

Stage Four: Identification of Causes of Mistranslations

In the fourth stage, each error was analysed according to the presumed cause of the mistranslation. The reasons for the mistranslations, were coded by number according to the order in which they appeared on the sheet. The coding was written above each proposition and a tick placed in the appropriate block on the revised MAT sheet.

2.6.2 Data from the Semi-structured Interviews

The data obtained from the post-session interviews was analysed using a complex series of procedures depicted in Figure 4.

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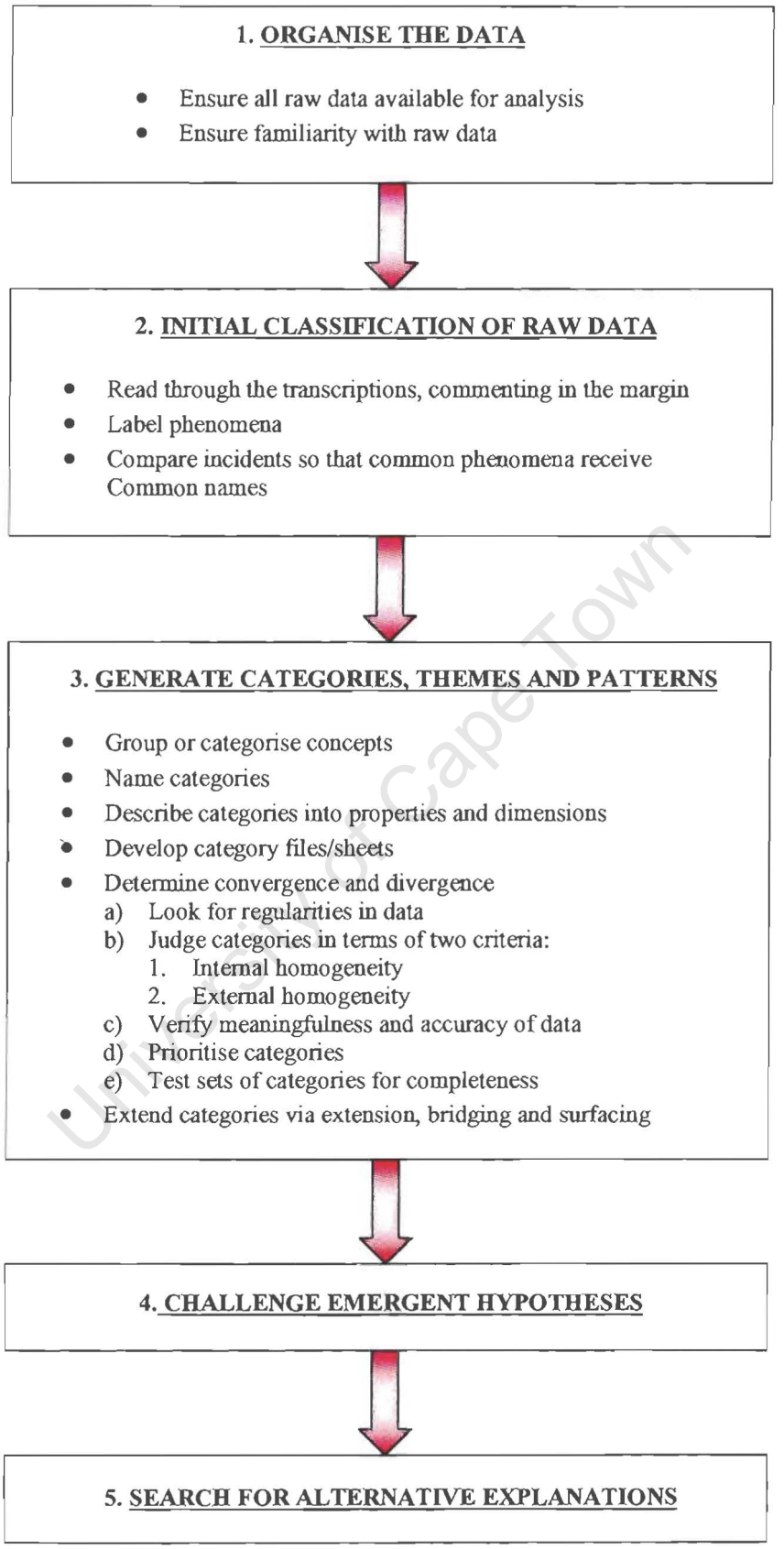

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Figure 4: Flow Diagram Depicting the Stages Involved in the Data Analysis

An examination of the qualitative analysis procedures from a number of sources (Corbin & Strauss, 1990; Patton, 1990; Marshall & Rossman, 1995; Michelson, 1998) allowed for the development of the procedure depicted in Figure 4.

These stages will now be discussed in more detail:

Stage One: Organisation of the Data

The first step of the analysis procedure was to ensure that all raw data had been gathered and was available for analysis. The transcription of the post-session interviews, as well as numerous additional read-throughs of the raw data allowed the researcher to become familiar with the information, thereby facilitating further analysis (Patton, 1990; Marshall & Rossman, 1995). Two copies of each transcript were made, one as an original and another for later cutting and pasting purposes.

Stage Two: Initial Classification of the Data

This stage marked the beginning of the coding process which takes place in content analysis. The researcher was required to read through each of the 18 transcripts from the semi-structured interviews and make comments in the margin (Patton, 1990). These comments included ideas and perceptions of particular observations, sentences and paragraphs. Each of these incidents, ideas or events, in turn were given a label that was felt to represent that phenomenon. Incidents were then compared so that common phenomena would receive common names (Corbin & Strauss, 1990). The data was conceptualised in this way to facilitate the large amount of raw data in the transcriptions.

Stage Three: Generate Categories, Themes and Patterns

Once the phenomena had been identified, they were grouped together into categories. Categories were given names that were more abstract than the concept names, but were still felt to be transparent enough to remind the researcher of the raw data. Categories were further developed in terms of their properties and dimensions (Corbin & Strauss, 1990). These characteristics formed the basis for differentiating categories and sub-categories.

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Patton (1990) suggests that data should be organised into topics and files. Each category was therefore allocated a separate category sheet. After completing a detailed coding procedure, the information pertaining to that topic was then cut out from a copy of the original raw data and placed onto the category sheet.

At this stage of the analysis, categories were examined for divergence, convergence and completeness as proposed by Guba (1985 in Patton, 1990). This entails "fleshing out" patterns and categories in order to determine what could be appropriately fitted together in particular categories. This was achieved by:

a) Looking for regularities in the data
b) Judging categories in terms of internal homogeneity (the extent to which data in a category holds together) and external homogeneity (the extent to which differences in a category are bold and clear).
c) Working back and forth between data and classification systems to verify meaningfulness and accuracy of placement of data within certain categories.
d) Prioritising categories, by determining which categories were more important according to features of saliency, uniqueness and credibility.
e) Sets of categories being tested for completeness by:

- Extension – building on items of information already known.
- Bridging – making connections between different items.
- Surfacing – proposing new information that should fit and verifying its existence.

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At this stage certain categories were joined together to form themes, while other categories were reduced to variables in the study. Themes are defined by Ely (1991) as statements of meaning that run through all or most of the important data. Their impact is thought to be primarily emotive and factual (Ely, 1991). Categories were also laid out in terms of priority so that they could be reported on in this order in the Results & Discussion section of the study.

Stage Four: Challenge Emergent Hypotheses

At this point, the data was searched in order to challenge the established hypotheses and to find information that may not be in agreement with the hypotheses (Corbin & Strauss, 1990).

Stage Five: Search for Alternative Explanations

When challenging the patterns that seemed to be apparent, alternative explanations were sought out, identified and described. It was deemed necessary to demonstrate why a particular explanation was the most plausible (Corbin & Strauss, 1990).

2.7 RELIABILITY

Research is said to be trustworthy if the research process is carried out fairly and the product is closely representative of the informants involved. Thus, a number of methods were employed in this study in order to enhance and determine the rigour of the data analysis procedure. This had to be undertaken at a number of different levels in the research to ensure that the data was accurate throughout.

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2.7.1 Confirming the Accuracy of the Transcription and Translation of the Data

The Xhosa and the English data were checked separately as it was assumed that the Xhosa data had two possible levels of breakdown - in the transcription and in the translation phases, whereas the English data had only one possible level of breakdown - in the transcription phase.

2.7.1.1 Xhosa Data

Twenty percent of the transcribed and translated Xhosa data was rechecked by the original translator and transcriber (intra-rater reliability) and 100% of the transcribed and translated Xhosa data was checked by two additional first language Xhosa speakers for inter-rater reliability (Brislin, 1986). Each time the Xhosa data was checked and altered, a new set of data was formed. The original data underwent three different modifications

(formulating the revised data, the second revision and the final set of data) before it was ready for analysis purposes. The participants who assisted with the checking will hereafter be referred to as P1, P2 and P3.

The rationale for undergoing such detailed revisions of the Xhosa translations was that, as Muller (1994) pointed out, there can be no authoritative translation from one language to another. Furthermore, Brislin (1986) emphasises the need for conceptual as opposed to purely linguistic equivalence when translating from one language to another. Consequently, all of the various stages of translation were useful to the researcher when making statements about meaning. Field notes relating to additional explanations of meaning were added in brackets to the final set of data to assist the researcher in making accuracy judgements. This method of using three raters, was preferred to the use of back translation (see Brislin, 1986), as one-to-one word equivalents across languages were not always likely to be found. Thus, the procedure depicted in Figure 5 below, was adopted for confirmation of the accuracy of the Xhosa data.

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Figure 5: Flow Diagram Depicting the Stages Involved in Confirming the Accuracy of the Xhosa Data

2.7.1.2 English Data

To ensure intra-rater reliability, the researcher validated all the English data from the Xhosa sessions whilst working with P1 on validating the Xhosa data.

In addition to this, 20% of the English data, from the English-only and the English-Xhosa assessment interviews and post-session interviews, was reviewed by an L1 English speaker, to ensure inter-rater reliability. Twenty percent of the data was chosen from a cross-section of recorded sessions (English-only discussions, and English-Xhosa discussions with the caregivers). The data was randomly selected in that any part of these sessions was selected for the purpose of reviewing.

Based on suggestions by Cucchiarini (1995), a word-by-word percentage agreement procedure was used to determine inter-rater reliability of transcribed English data in an objective manner. The following formula was employed (Cucchiarini, 1995):

$$\frac{\text{Number of Agreements}}{\text{Number of Agreements + Number of Disagreements}} \times 100$$

Figure 6: Formula for Inter-rater Reliability

Inter-rater word-by-word agreements for transcriber 1 vs. transcriber 2 across 18 transcribed post-interviews are presented in Table 2.8 below.

Table 2.8: Inter-rater Transcription Reliability

	Interview 1	Interview 2	Interview 3	Interview 4	Interview 5	Interview 6
Rater 1 & 2	96.59%	99.25%	96.24%	97.56%	96.13%	98.79%
	Interview 7	Interview 8	Interview 9	Interview 10	Interview 11	Interview 12
Rater 1 & 2	97.72%	99.39%	97.29%	98.02%	99.32%	99.17%
	Interview 13	Interview 14	Interview 15	Interview 16	Interview 17	Interview 18
Rater 1 & 2	99.73%	99.16%	98.77%	97.55%	99.18%	98.65%

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The mean percentage word-by-word agreement across 18 interviews for transcriber 1 and 2 was 98.25%. This result indicates high inter-rater transcription reliability. Subjectively, it was found that there were no errors of content, in that there were no propositions missing, however some ritual utterances and prompts were missing. Where notable discrepancies arose in the interview transcriptions, changes were made to the transcripts prior to further analysis.

2.7.2 Confirming the Accuracy of the Preparation of Data for the Mistranslation Analysis

The researcher once again relied on intra-rater reliability and inter-rater reliability to ensure the accuracy of the preparation of the data for analysis.

2.7.2.1 Intra-rater Reliability

A total of 92 pages of translated transcription from the initial assessment interviews were prepared for data analysis. The researcher re-checked a random 20% of this data to ensure that the decisions which had been made pertaining to the following were consistent:

- Division into propositions
- Matching of propositions
- Contribution of propositions
- Neutrality of propositions

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2.7.2.2 Inter-rater Reliability

The method of error analysis depicted in Figure 4 was explained to a participant (P4), so that she would be able to conduct the analysis in the same manner as the researcher. P4 prepared a random 20% of the data for analysis. Her results pertaining to the above decisions were then compared to the results of the researcher. Where there were discrepancies, the researcher and the assistant engaged in discussion and modifications were made, based on joint decision-making.

2.7.3 Confirming the Accuracy of the Mistranslation Analysis

2.7.3.1 Intra-rater Reliability

The researcher checked the 20% of randomly selected data that had been prepared for the analysis.

2.7.3.2 Inter-rater Reliability

The assistant P4 checked the randomly selected 20% of the data that had been used for checking the preparation of the data. No significant discrepancies were noted.

2.7.4 Validating the Data at the Level of Thematic Analysis

Validation of the data at this level was based on suggestions by Patton (1990), Polgar and Thomas (1991), DePoy and Gitlin (1994), and Joubert et al. (1997). These suggestions are outlined below.

2.7.4.1 Data on Characteristics of the Informants

Joubert et al. (1997) state that it is important to report on the characteristics of the respondents in order to give an indication of the reliability of the responses. It was suggested that characteristics such as training, experience and the agendas of the informants be made known so that the results could be correctly interpreted within context.

According to Polgar and Thomas (1991), research demonstrates that in our everyday communications and social interactions, we take an enormous amount of cultural context for granted and we tend to bracket this as obvious or common sense. When the cultural backgrounds of individuals diverge, the understanding of personal meaning becomes less obvious. Consequently, we need to establish what cultural background the informants in the study come from and what their previous training and experience are, in order for their perceptions to be analysed in context. For these reasons, the biographical details of all informants were included as well as, in the case of the trained interpreters, details of

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training and experience and descriptions of the programmes to which the informants were affiliated.

2.7.4.2 Audit trail

It has been reported that in qualitative research such as this, the researcher is more a part of the phenomenon being investigated than in quantitative research (Polgar & Thomas, 1991). However the advantages of using a human measuring instrument, is that we are more adaptable and multi-purpose than even the most sophisticated machinery and we can observe subtle behavioural changes as well as verbal and non-verbal cues in our subjects.

One way of indicating the train of thought of the researcher, is through an audit trail. An audit trail refers to the thinking and action processes involved in obtaining results and involves the researcher reporting on his or her train of thought (DePoy & Gitlin, 1994). This was felt to be achieved via the following: post-session field notes, notes on procedures in methodology, notes on the construction of materials in the methodology and notes on the utilisation of the constructed materials in the methodology.

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2.7.4.3 Triangulation

Triangulation is a process whereby one source of information is checked against one or more other sources of information (DePoy & Gitlin, 1994). According to Patton (1990), the combination of methodologies in the study of the same phenomena, strengthens the study design. It can involve using several kinds of methods or data, including using both quantitative and qualitative approaches. Any given study can include several mixes of the approaches by including several measurement approaches, varying design approaches and varying different analytical approaches to achieve triangulation (Patton, 1990). Using triangulation is recognition that the researcher needs to be open to more than one way of looking at things.

Denzin (1978 in Patton, 1990) stated that no single method ever adequately solves the problem of rival causal factors. Furthermore, each method reveals different aspects of empirical reality, and consequently multiple methods should be employed in every investigation (Denzin, 1978 in Patton, 1990).

Four basic types of triangulation specified by Denzin (1978 in Patton, 1990) were used to strengthen the validity of this research in the following ways:

a) Data triangulation (the use of a variety of different data sources in one study)

The following different types of data were compared:

- Video recordings: allowed for a comparison of what the informants had said with what the translators had written; allowed for a comparison with the perceptions of the informants.
- Transcriptions from general interviews: could be compared to the specific situation.
- Transcriptions from specific interviews: perceptions of what occurred could be compared to the video-recording of what actually occurred.
- Field notes.
- The Revised Mistranslation Analysis Tool (MAT): Positive and negative contributions of the trained and untrained interpreters could be compared to the perceived contribution of the interpreters from the specific post-session interviews.

b) Investigator triangulation (the use of several different investigators)

Although the researcher was essentially the chief investigator, the perceptions of the clinician and the caregivers in the post-session interviews, provided for an evaluation of the interpreter by other investigators. The interpreter provided another perspective by providing an evaluation of herself.

c) Theory triangulation (the use of multiple perspectives to interpret a single set of data)

Qualitative research is data-driven as opposed to being theory-driven. Theory is generated from the data collected i.e. it is grounded in the data (Glaser & Strauss, 1967 in Cassell & Symon, 1997). This allows for flexibility in the process of conducting research and allows the researcher to formulate new hypotheses and alter old ones as the research progresses (Cassell & Symon, 1997).

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d) Methodological triangulation (the use of multiple methods to study a single problem or programme)

Methodological triangulation was used in that observational data (from the video-recordings and the mistranslation tool analyses) could be compared to the interview data.

According to Patton (1990), observational data, especially participant observation, permits the researcher to understand a programme or treatment to an extent not entirely possible using only the insights of others obtained through interviews. The purpose of observational data should be to take the reader into the setting that was observed, and thus observational data must have depth and detail. The skilled interviewer must also be a skilled observer, able to read non-verbal messages, sensitive to how the interview setting can affect what is said, and carefully attuned to the nuances of the interviewer-interviewee interaction and relationship (Patton, 1990).

Polgar and Thomas (1991) identified a number of different observer roles. The level of participation chosen requires a tension between the requirements of objective and independent analysis, and the proximity from which the social and clinical phenomena can be studied. The following observer roles were undertaken by different informants in this research:

a) Participant as observer: Participates fully in the situation in the study and discloses intentions to the other participants e.g. researcher in the semi-structured post-session interviews.

b) Observer as participant: Observer makes no pretence of participation but does observe and examine records e.g. researcher in the initial assessment interview setting.

2.7.4.4 Subjective Assessment of the Interviews Immediately After the Recording

Directly after each interview, the researcher wrote down brief field notes on the positive and negative aspects of the each session, as well as the researcher's feeling about the responsiveness of the informants. In order to make this as easy and as quick as possible

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to administer, the researcher constructed a short checklist to be used after each interview. The checklist was based on suggestions from several researchers (Patton, 1990; Marshall & Rossman, 1995; Evans, 2000) and included comments on the following:

- Others present during the interview
- Distractions during the interview
- Interviews affected by others present and distractions
- Informant characteristics
- General
- Equipment check
- Ideas from the interview which needed to be followed up.

2.7.4.5 Missing Data

The incidence of data that could not be transcribed was minimal (Joubert & Katzenellenbogen in Joubert et al., 1997). The little data that could not be transcribed could be attributed to one of the following:

- Speaker variables: Some of the caregivers had very soft voices which contributed to poor sound quality.
- Environmental/situational variables: At times, background noise at the community-based site interfered with the sound quality.

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3. RESULTS & DISCUSSION

In this section, the findings from the post interviews with the informants, the revised MAT and general observations regarding non-verbal behaviours and body language from the video-recorded initial assessment interviews are discussed. The results are considered under each of the themes that emerged from the thematic analysis of the semi-structured post- interviews. The themes are listed in Table 3.1 below.

Table 3.1: List of Themes

TRANSACTION
INTERACTION
NEED FOR INTERPRETERS IN HEALTH CARE
ROLES OF INTERPRETERS
TRAINING
SATISFACTION

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The most prominent findings from this study emerged from the realisation that communication is a dynamic, flexible and multifaceted activity, and thus successful communicative interactions are dependent upon more than purely transfer of information. Embedded within the transfer of information are aspects such as interpersonal interaction, non-verbal aspects such as eye contact and body language, as well as the innate qualities of the communicators, to mention a few. All of these aspects impacted on the success of the communicative interaction, and thus cannot be ignored or isolated without losing the intentions of the communicators. This becomes particularly significant when considering that in this study, communicative intentions as well as verbal messages are being relayed by interpreters between two communicative partners, the clinician and the caregiver.

It thus became apparent that it was essential to distinguish between 'transactional' and 'interactional' communication. These terms were first used in sociolinguistics and discourse literature (Watzlawick, Beavin & Jackson, 1967). Very simplistically, 'transaction' would refer to the actual content of the language being conveyed, while 'interaction' would refer to how the information is being conveyed. Oller (1979) also distinguished between 'factive' (facts, communication) and 'emotive' (attitudes, feelings, interpersonal interaction) aspects of communication. In addition, Brown and Yule (1983) have divided communication into different levels, distinguishing between 'message transmission' or 'transaction', and the more 'socio-interpersonal' level of communication or 'interaction'. Other researchers have also used these principles to assess the communicative competency of aphasic patients, and have found that it is essential to give transaction and interaction equal weight, in the sense that communication is impaired when either level is disrupted (Kagan, 1995; Simmons-Mackie & Dominico, 1995; Simmons-Mackie, 1998).

Thus, there is much theoretical support for the findings of this study highlighting the multi-dimensional nature of communicative interactions. This implies that interpreters are indeed faced with a mammoth task of incorporating both transactional and interactional aspects of communication into their interpretation of the clinicians' and caregivers' utterances.

The objective results from the revised MAT are discussed within the theme of transaction, and general observations regarding non-verbal and body language are discussed under the theme of interaction.

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3.1 TRANSACTION

The value of the use of language to transmit information is embedded within the discourse literature where transaction is seen as 'an expression of content' or 'conveyance of factual information' (Brown & Yule, 1983). When viewed from an interpreting perspective, it would appear that one of the crucial duties of an interpreter would thus be conveying factual information from the clinician to the caregiver as well as from the caregiver to the clinician. In this study, it became clear that implicit in this duty of transferring information, was the necessity for the information to be transferred accurately. This

appeared to be partially dependent on the interpreter's understanding of the information being conveyed. In addition, the use of a number of strategies by the clinician and the interpreters appeared to either facilitate or impair accuracy. As a result, a number of aspects that emerged within the theme of transaction are discussed, including accuracy and understanding.

3.1.1 Accuracy

As previously noted, the bulk of research undertaken on clinical interpreting from a bio-medical perspective has focused on the accuracy of the interpreting process, particularly as it would impact upon diagnostic assessment and management (Muller, 1994). These analyses have been drawn from a large sample of recorded clinical interviews, and most of the authors have referred to interpreting error as a result of the interpreter lack of knowledge in a number of crucial areas, which will be discussed shortly. Furthermore, the negative impact of interpreters has primarily been highlighted in past research. However, in this study, an attempt to highlight and discuss the positive contribution of interpreters, as opposed to only referring to the negative contribution in isolation is undertaken. Embedded in this discussion is a comparison of trained and untrained interpreters.

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In this study the following aspects were considered and found to be important with regards to accuracy:

- Comparison of the number of accurate vs. inaccurate translations across trained and untrained interpreters
- The number of mistranslations occurring in the interpreted initial assessment interviews across trained and untrained interpreters
- Comparison of the type of mistranslations occurring and examination of the possible causes of the mistranslations
- Examination of reasons for accurate translations
- The effect of direction of translation on the number of mistranslations across trained and untrained interpreters
- Examinations of whether the subjective perceptions of the informants (caregivers, clinician and interpreters) were in agreement with the objective accuracy ratings of the interpreters in interpreted sessions.

In the semi-structured interviews, the caregivers as well as the clinicians were asked to judge the degree of the trained or untrained interpreter's accuracy. What was overwhelmingly clear is that the perceptions of the clinician and the caregivers with regards to the accuracy of the interpreted interviews, contrasted significantly. The caregivers were always satisfied with the degree of accuracy of the interpreters, both trained and untrained, while the clinician was not. The clinician was decidedly more satisfied with the accuracy of the trained interpreters, as compared to the untrained interpreters. Despite this, mistranslations were noted by the clinician across trained and untrained interpreted interviews, but varied with regards to the degree and the impact that the mistranslations had on the interpreted consultation. The untrained interpreters were said to have many more mistranslations which, as a result affected the flow of the interview and the understanding of the clinician. Although the clinician thought that two out of the three untrained interpreters might have sometimes conveyed the main factual message, she felt that the subtleties of conversation were not always conveyed. Mistranslations within the untrained interpreted interviews appeared to be overwhelmingly obvious to the clinician.

Cl: *"She* [UI1] *covered some of what I said, but it definitely wasn't a direct translation"*

The results from the revised MAT (to follow) reveal that the clinician was more accurate in her subjective opinion of the accuracy of the interpreters, as opposed to the caregivers' subjective opinion. The caregivers' general satisfaction with both the trained and untrained interpreter's accuracy may stem from contentment that they are being assisted in their own language, since they are unable to speak the languages of power in South Africa, namely English and Afrikaans. Thus, it is believed that perhaps they found it inappropriate to complain or pass judgement on the interpreters. These aspects will be discussed in more depth in Section 3.1.1.5.

3.1.1.1 Number of Accurate vs. Inaccurate Translations across Trained and Untrained Interpreted Interviews

In this study, distinct differences in accuracy between the trained and untrained interpreted interviews were noted. To allow for comparison, percentage values of accuracies and

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inaccuracies were averaged across the individual trained and untrained interpreted interviews.

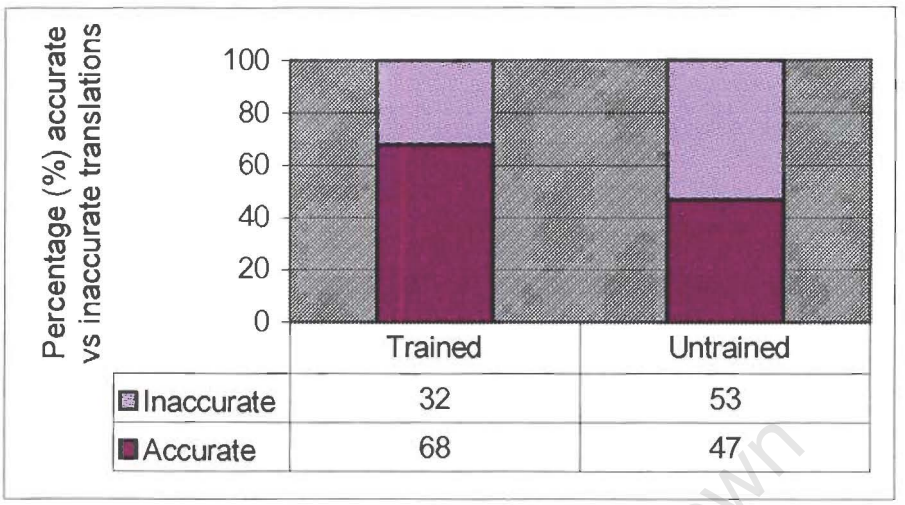

Figure 7: Proportion of Accurate vs. Inaccurate Translations across Trained and Untrained Interpreted Interviews

As can be seen in Figure 7 above, the proportion of accuracies found in the trained interpreters' translations far outweighs those in the untrained, 68% and 47%, respectively. Furthermore, inaccuracies are decidedly more prevalent in the untrained interpreters' translations (32% trained and 53% untrained). The percentage of inaccuracies produced by the untrained interpreters are similar to those found by Ebden et al., (1988), who reported that untrained interpreters mistranslated 23-52% of the questions asked by doctors, and some of the questions were not translated at all. Although the average percentage of inaccuracies produced by the trained interpreters does fit into Ebden et al.'s (1998) range of inaccuracies, it is clearly the lower end of the range, while the untrained interpreters occupied the higher end of their range.

As previously mentioned, these results were further analysed to determine the types of mistranslations, the contribution of the mistranslations (positive or negative), as well as the causes for the mistranslations and the reasons for the accurate translations.

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3.1.1.2 Type of Mistranslations: Additions and Omissions

The extent to which the additions and omissions appeared was examined across trained and untrained interpreted interviews.

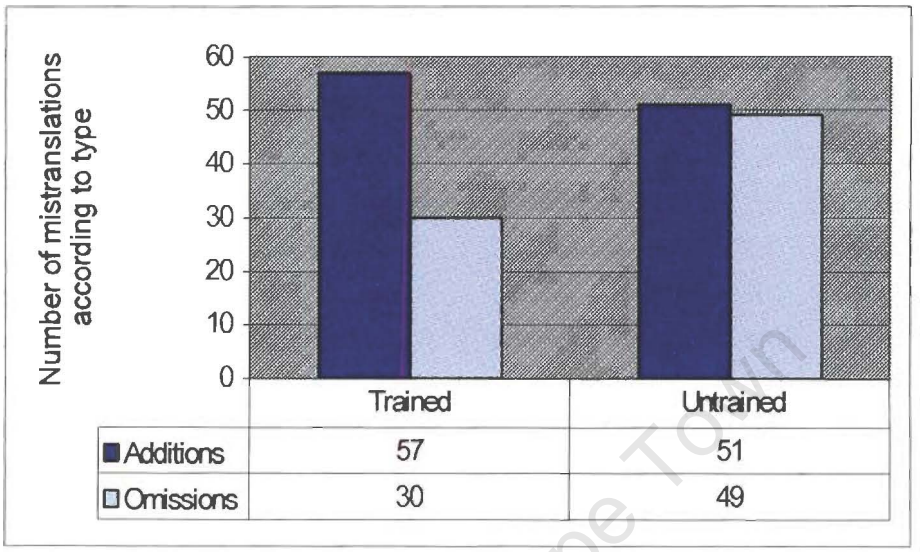

Figure 8: Number of Mistranslations According to Type - Additions and Omissions

Figure 8 above indicates that both additions and omissions were found across trained and untrained interpreted interviews. Both the trained and untrained interpreters used similar amounts of additions, however the untrained interpreters used substantially more omissions than the trained interpreters. Thus, untrained interpreters, to a larger extent than the trained interpreters, were not translating everything that the clinician and caregivers had said. It is proposed that this is due to their inexperience in interpreting, lack of knowledge of what is expected of them in an interpreted interview, as well as the possibility that they may not have understood everything that the clinician and the caregiver were saying.

The clinician felt that both the trained and the untrained interpreters added information to the original utterance. However, the additions from trained interpreters were perceived by the clinician to be more positive than the additions from the untrained interpreters, in that they facilitated the caregivers' understanding of the clinician's original utterance.

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Cl: *"... there were times where her* [TI2] *translation was a lot longer than what I said and I think it particularly happened where what I'd said was difficult to translate directly, but I think it was a positive addition"*

Evans (2000) also reported that the expansions (additions) by the trained interpreter in her study, were often of assistance to the caregiver. Launer (1978) stressed that additions may be legitimate when they increase the understanding of both parties, especially when the question is phrased in bio-medical or inaccessible language. Muller (1994) reported that at times, the interpreter attempted to clarify the doctor's questions for the patient by adding extra concepts to facilitate understanding. In contrast, another type of addition, such as initiated questions, could lead to the interpreter using leading questions, which could result in misunderstanding or even misdiagnosis, since the clinician would have no way of knowing that this was occurring. This will be discussed further in Section 3.1.1.5.

In contrast, the clinician felt that omissions were more prevalent amongst the untrained interpreters than the trained interpreters, and that when the trained interpreters did omit utterances, it was likely to be unimportant, and not did not disrupt the interview or cause as much confusion as it did with the untrained interpreters.

Cl (about UI1): *"I wasn't sure that it* [the information] *was accurate, because the mom would give a lot of information and then not as much came back and vice versa."*

Cl (about TI3): *"It's possible that things were left out, but probably less meaningful things, I think the main message definitely got across"*

The clinician's opinion is supported by the results of the revised MAT, which indicated that the untrained interpreters had significantly more omissions than the trained interpreters (Figure 8).

These findings further support those reported by Marcos (1979), who suggested that the large number of omissions found in untrained interpreters was thought to be a result of the interpreter's poor language competence and translation skills. Furthermore, it has been suggested that interpreters' omission of the patients' utterances effectively seem to delete

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the patients' statements and render them invisible. In addition, when the interpreter omits seemingly "meaningless" phrases "to give a short answer", important diagnostic information might be lost, which impacts on the management of the patient (Price, 1975, p. 265).

The trained interpreters admitted to lengthening the clinician's original utterances. They stated that they did this in order for the caregivers to understand. They saw it as part of their role as *"cultural brokers"*, in that they often added more culturally appropriate examples to facilitate understanding of the caregivers. This is confirmed by the large number of additions as opposed to omissions used in trained interpreted interviews. The untrained interpreters were also aware of using additions, however they were unaware of the negative impact of the additions they used. They felt that the additions they made were useful to the caregivers in terms of assisting them to understand certain aspects. Nevertheless, results from the revised MAT revealed that the impact of their additions were largely negative, which will be discussed shortly. This is in accordance with Vasquez & Javier (1991), who reported that even well intentioned untrained interpreters usually lack a sufficient appreciation of the possible consequences of an inaccurate interpretation for the patient's treatment.

One untrained interpreter (UI1) mentioned that she did not always repeat what the clinician said accurately and left things out at times. This appeared to be because she assumed that the caregiver had understood the question in English and that she only struggled to express herself in English.

UI1: *Sometimes I'm not telling her* [the caregiver] *everything that the Cl. is asking, because I think this lady* [the caregiver] *knows what she* [the clinician] *is asking her.*

This may imply that the untrained interpreter is adopting the role of an "editor", who selects which information is important. This is considered to be problematic in light of the interpreter's limited knowledge within the field of Speech-Language and Hearing Therapy, since the interpreter may be unlikely to realise the clinical significance of what was omitted.

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The above-mentioned findings are in agreement with Vasquez & Javier (1991) who reported that additions and omissions were the error types that occurred most frequently in interpreted interviews. They reported that these types of errors tend to occur more frequently with untrained interpreters because they are more likely to take shortcuts or use literary license. Although omissions occurred more frequently in untrained interpreters in this study, additions were slightly more prevalent in trained interpreters and were more likely to be considered helpful because they facilitated increased understanding of the caregivers or the clinician.

3.1.1.3 Contribution of Mistranslations

As previously mentioned in Section 2.6.2.2, mistranslations can either be helpful or unhelpful. In this study, and as defined by Evans (2000), mistranslations which were regarded as being *helpful*, were termed *positive* and mistranslations which were regarded as being *unhelpful* were termed *negative*. In this study, the relative positiveness or negativeness of a mistranslation is referred to as its contribution.

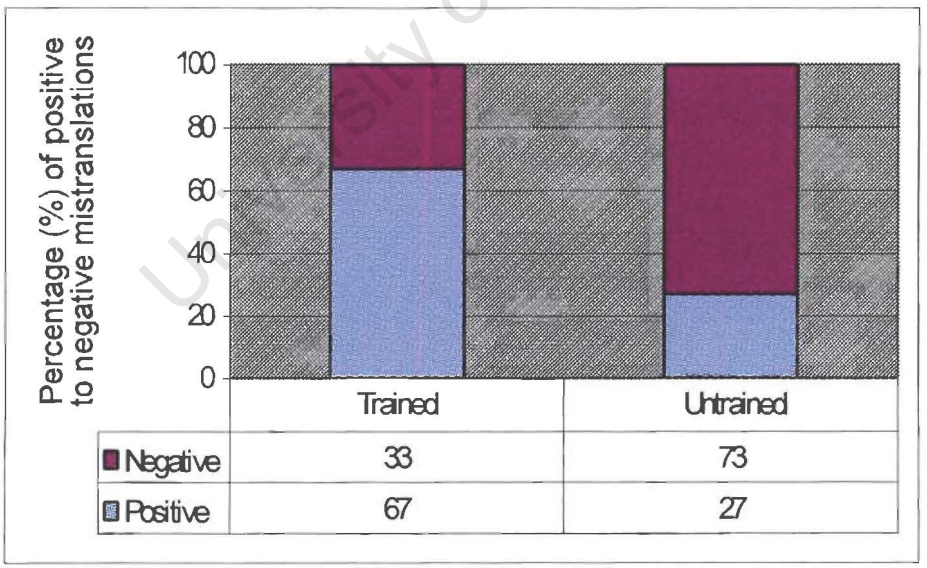

Figure 9: Proportion of Positive to Negative Mistranslations across Trained and Untrained Interpreted Interviews

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As can be seen in Figure 9, the trained interpreters presented with considerably more positive mistranslations than untrained interpreters, while the untrained interpreters presented with more negative mistranslations than the trained interpreters.

This was confirmed by the clinician, who felt that the additions by the trained interpreters resulted in the caregivers having increased understanding of medical concepts and terms. In contrast, the omissions by the untrained interpreters of medical concepts and terms led to confusion in the caregivers, and the interpreter not reporting this confusion back to the clinician led to the clinician being unaware of the need for further explanation.

These findings are in accordance with Evan's (2000) who indicated that during initial interview sessions with a trained interpreter, the mistranslations were far more likely to result in a positive than a negative outcome.

These findings are of particular significance, since case history findings in conjunction with diagnostic testing results are the basis upon which a diagnosis is made by the clinician. This implies that a clinician is more likely to make a misdiagnosis with an untrained interpreter than with a trained interpreter. The possibility of misdiagnosis in interpreted interviews has been identified as a great concern of medical personnel (Smit, 1999).

Figures 10 and 11, indicate the contribution of additions and omissions across trained and untrained interpreted interviews.

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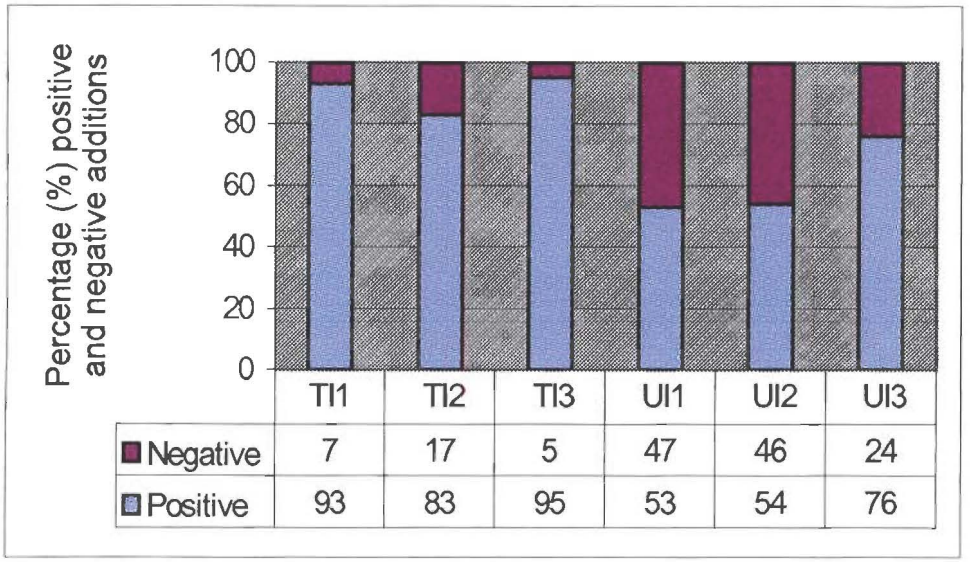

Figure 10: Contribution of Additions across Trained (TI) and Untrained (UI) Interpreted Interviews

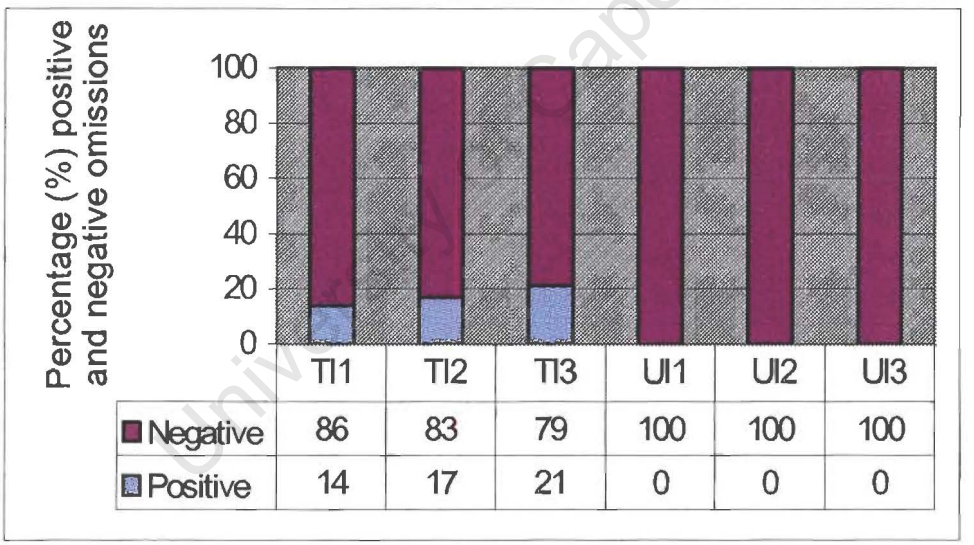

Figure 11: Contribution of Omissions across Trained (TI) and Untrained (UI) Interpreted Interviews

As can be seen in Figures 10 and 11 above, contribution of mistranslations appear to vary as a function of mistranslation type. In Figure 10, the majority of the additions from the trained interpreters had a positive contribution, while the additions from the untrained interpreters had equally positive and negative contributions. The fact that very few of the trained interpreters' additions were negative, implies that the trained interpreters added

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information that was useful to the caregivers or the clinician. This may be due to their skills acquired during training, as well as a result of their exposure to interpreted interviews within Speech-Language and Hearing Therapy (i.e. field-specific experience). This also verifies the clinician's perceptions of the contribution of the trained interpreters' additions.

It is clear from Figure 11 that omissions were generally seen to be negative across trained and untrained interpreters, although the trained interpreters had a few positive omissions, none of which were seen in the untrained interpreted interviews. Utterances were seen to be positive omissions when they were omitted due to their replacement with more culturally appropriate language, or when lengthy utterances were summarised to increase the understanding of the caregiver or the clinician.

3.1.1.4 Causes of Mistranslations

While the focus of past research has largely been on the possible causes of negative mistranslations, in this study the causes of *both* negative and positive mistranslations were examined.

i) Causes of Negative Mistranslations

As previously discussed in Section 2.6.2.2, negative mistranslations were broadly divided into two categories, namely textual and non-textual factors. Textual factors were considered to be inherent in the text, such as the 'use of medical terminology', while non-textual factors were considered to be external contributors of mistranslations, such as 'selective interpretation'. Division of negative mistranslations into these categories, shifts the focus of the blame from the interpreter (Muller, 1994), towards those factors that are inherent within the content of the message or in the context in which the message was spoken (Evans, 2000). It is hoped that the insights gained from identification and analysis of the causes of negative mistranslations could be used in training clinicians and interpreters in the most common causes of negative mistranslations. In addition, it is proposed that a heightened awareness of the causes of the negative mistranslations, as well as a description of possible strategies to prevent them, will ameliorate or lessen their effect in future interpreted consultations.

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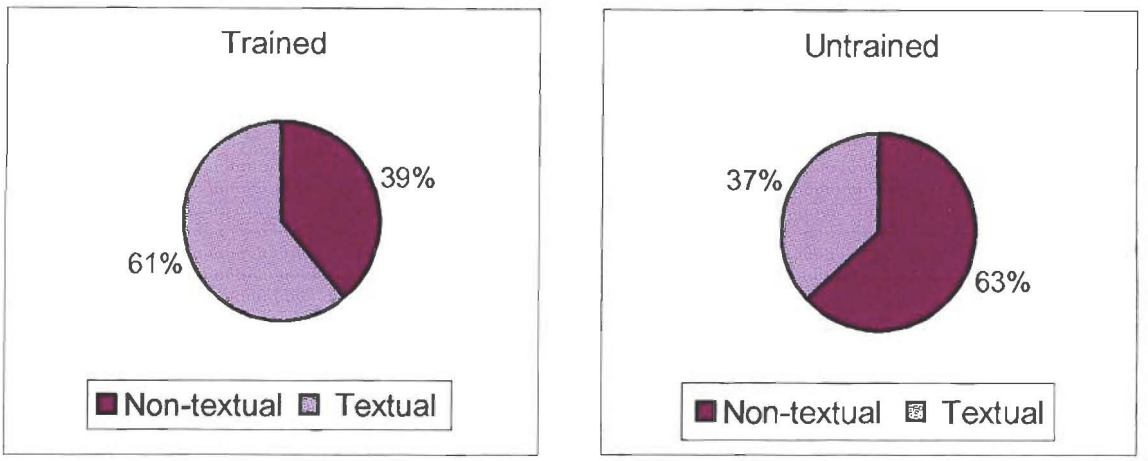

Figure 12: Proportion of Negative Mistranslations caused by Textual and Non-textual Factors across Trained and Untrained Interpreted Interviews

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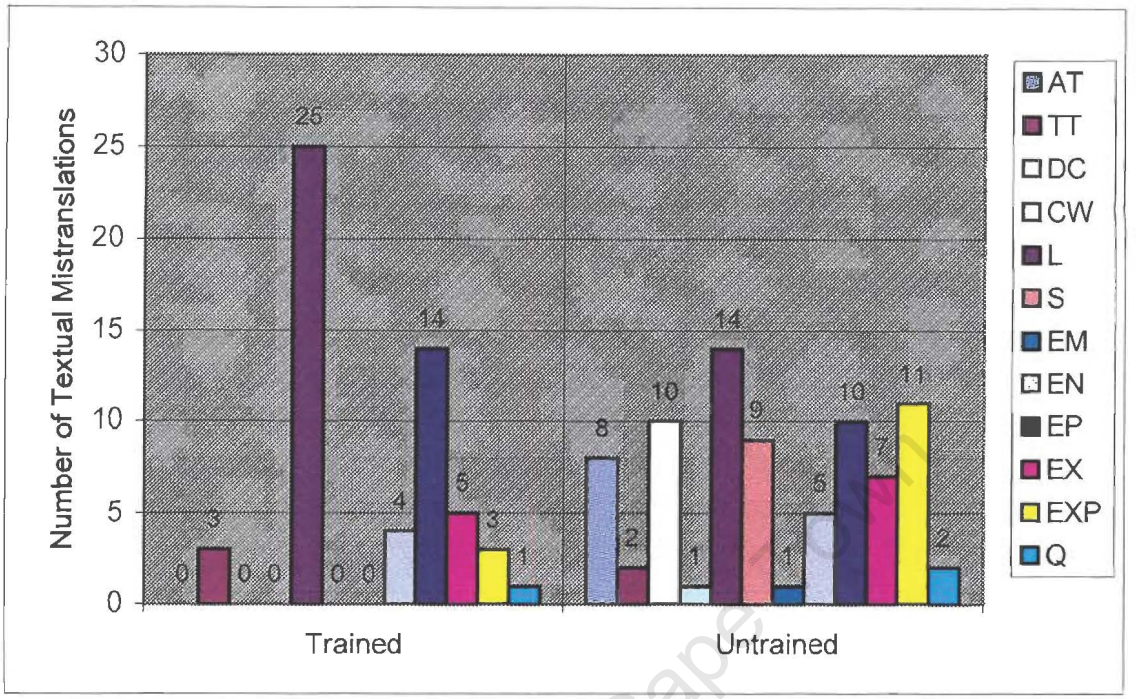
In addition to the untrained interpreted interviews having substantially more negative mistranslations than the trained interpreters, Figure 12 above indicates that the proportion of textual to non-textual negative mistranslations are very different across trained and untrained interpreted interviews. Non-textual factors are clearly more prevalent than the textual factors within the untrained interpreted interviews, while textual factors are more prevalent within the trained interpreted interviews. This implies that most of the negative mistranslations by the untrained interpreters were most likely as a result of interpreter traits, while most of the negative mistranslations by trained interpreters were inherent in the text, or possibly as a result of clinician traits. These results differ from Evans (2000) findings, which showed textual and non-textual factors to be in equal number with trained interpreters. This is possibly due to the differing characteristics of the session types investigated across studies. However, the larger contribution of non-textual factors in untrained interpreters in this study, has implications for minimising some of the negative impact when using untrained interpreters, since many of these factors could be eliminated or reduced through fore-planning on the part of the clinician and the interpreter. These factors should also be included in the training guidelines for interpreters and professionals working with interpreters.

In order to identify which specific textual factors were resulting in negative mistranslations, an analysis of the type of textual factors was undertaken.



Key:					
	AT - Anatomical Term		L - Lengthy Utterance		EP - Expansion
	TT - Technical Term		S - Summary		EX - Example
	DC - Difficult Concept		EM - Emotive Content		EXP - Explanation
	CW - Connoative Word		EN - Encouragement		Q - Question

Figure 13: Number of Mistranslations According to Textual Factors across Trained and Untrained Interpreted Interviews

As can be seen in Figure 13 above, the most common cause of negative textual mistranslations within trained interpreted interviews was when the clinician used a lengthy original utterance which was then reduced by the interpreters. The second most common cause was when an utterance had been expanded by the clinician and then reduced by the interpreters. Omission of lengthy and expanded utterances differ by virtue of lengthy utterances being comprised of several unconnected propositions, while expanded utterances are connected to an initial proposition. As was expected, an analysis of type of mistranslation showed that omissions were used to reduce expanded and lengthy utterances. The propositions that were omitted were comprised mainly of detailed factual information, as well as more abstract concepts and anatomical or technical terminology.

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Propositions within lengthy original utterances were seen to be omitted when an utterance consisted of four or more propositions. The utterances at the beginning and the end were more likely to be relayed accurately, while the propositions in the middle of the utterance, were more likely to be omitted or substituted.

These findings are in agreement with Evans (2000) who also found that omissions of expanded utterances were the most common causes of negative mistranslations used by the trained interpreter in her study. However, in Evans' (2000) study, there was a large discrepancy between this cause and the other causes of negative mistranslations, where omissions of expanded utterances far outnumbered the other causes. This was in contrast to the findings in this study, which did not reveal as large a discrepancy between causes of negative mistranslations. These findings may be related to the fact that the same interpreter was used in all of the interpreted interviews in Evan's (2000) study, which might result in the primary causes of her negative mistranslations being magnified. In contrast, a series of three trained and three untrained interpreters were used in this study and their results were averaged as mentioned previously.

The causes of textual mistranslations within untrained interpreted interviews were more evenly distributed with fewer outliers, although omissions of lengthy utterances were seen to be slightly more common than other causes. This is in accordance with Marcos (1979) who considered length of utterance to be a crucial factor as longer utterances were more prone to mistranslation than shorter utterances.

Omission of expanded utterances as well as explanations were the more common textual mistranslations made by untrained interpreters in an interpreted interview. Omission of an explanation is differentiated from omission of an expanded utterance, by virtue of the omission of a reason why, as opposed to the omission of a connected utterance. The reasons for omission of expanded utterances in untrained interpreted interviews were thought to be similar to the reasons proposed above for the trained interpreted interviews. However, the omission of explanations, which did not feature as a common cause of mistranslation amongst trained interpreters, was seen to be more prevalent in untrained interpreters because they were thought to be more likely to have misunderstood complex explanations due to their lack of experience and knowledge in the field of Speech-

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Language and Hearing Therapy. As a result, it might have been easier for them to omit the complex explanations.

The clinician commented that she was more likely to notice that a mistranslation had occurred if textual as opposed to non-textual factors had resulted in the mistranslation. The most obvious examples of these were utterance length. The clinician would often query what the interpreter's translation of the caregivers' utterances, and ask if "that was all the caregiver had said". This implied that the clinician was often aware of summaries or reduction in length of the original utterance by the interpreters, both trained and untrained. However, she was unaware of the resultant impact of these omissions, since she did not know the content of the omitted utterances.

Other textual factors that have been frequently documented as causing mistranslations, were the clinicians use of anatomical, medical and technical terminology. These were considered problematic as the untrained interpreter's lack of knowledge within a field was likely to result in 'normalisation' of particular conditions, circumstantiality, tangential thinking, loose associations and blocking. In this study, mistranslations as a result of medical and anatomical terminology only occurred in untrained interpreters. The trained interpreters had no mistranslations of this kind, which could be explained by their familiarity with medical and technical terms, having had exposure to the field of Speech-Language and Hearing Therapy. This implies that field-specific training and experience in the field indeed appears to be important and might assist in alleviating some of these textual mistranslations.

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Omission of emotive content was not seen to be a substantial cause of mistranslations in this study. This was thought to be due to the nature of the interviews, which were not thought to be consistently highly emotive in content. As a result of this, these findings are in contrast with past research that has indicated that affective components of mistranslations were considered to be more prone to mistranslation than other parts. Marcos (1979) stated that interpreters tended to limit their translation to what the patient said without any regard for the manner in which they spoke. According to Gillis et al. (1982), within the field of psychiatry, translations were deemed to be more adequate for eliciting the hard diagnostic data of psychosis, than for fine discrimination of emotional states. In addition, Evans' (2000) findings revealed that omission of emotional content

was considered to be a substantial cause of mistranslations within the counselling sessions. Once again, when compared to this study, this is thought to be a result of differences in session type across studies, where the content of counselling sessions lends itself more to emotive language.

Previous research has documented lack of word equivalents in Xhosa as causing mistranslations (Crawford, 1994). According to Gillis et al. (1982) difficulties in translating are exacerbated when the two languages have different lexical and cultural roots, as do English and Xhosa. Lack of word or concept equivalents in the other language can hamper accurate translation, which should in its translated form still convey content, the form of talk (Swartz, 1998) and emotional content (Wood, 1993). Lack of word equivalents did not seem to occur frequently across trained or untrained interpreted interviews, however lack of concept equivalents did occur frequently in the mistranslations of the untrained interpreters. This could be due to their unfamiliarity with interpreting, and particularly their lack of field-specific knowledge.

Omission of questions and instructions also did not feature as significant causes of negative mistranslations across trained and untrained interpreted interviews in this study. This implies that the interpreters were more easily able to fit into the "black box" model of interpreting (Westermeyer, 1990) and translate word for word when there were basic questions or instructions to translate, as opposed to complex terminology or complex concepts.

Despite past research findings to the contrary, connotative words (i.e. words which hold associations or intentions) were not shown to have a negative effect on mistranslations in this research. As mentioned previously, this could be due to the initial interview consisting of a number of predetermined closed and open-ended questions that were not rich in metaphors or connotative language. Contrary to the findings in this study, Gillis et al. (1982) have reported that Xhosa-speakers of English may not know the complex terms and nuances of English metaphor and meaning and this could result in misunderstandings. This was not meant to imply that the Xhosa language is not capable of making subtle discriminations, since it is, but these discriminations might not lie in the same areas as in English (Gillis et al., 1982). Westermeyer (1990) also referred to connotative words, and stated that these often require the speaker to have knowledge about the deeper meaning of

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the word, or to be aware of the connotations that such a word has. Thus the connotation of the word might not be easily apparent to a second language English-speaker. It is proposed that these aspects should be considered in future research on interpreting practices.

It has been mentioned that the majority of literature on mistranslations in interpreted interviews puts the blame for the mistranslations on the interpreter and rarely on the clinician (Muller, 1994). Ironically, the interpreters have not previously been asked to comment on the possible causes of the mistranslations. This is perhaps due to the previous emphasis placed on the empiricist approach where all mistranslations were seen to be negative. In this study, the interpreters admitting to mistranslations would imply that they were performing poorly in their duties. Researchers might have found that asking interpreters about the possible causes of mistranslations, could reveal that the clinician is equally at risk of causing mistranslations. In this study, the interpreters did not comment on the clinician's contribution to mistranslations, but the clinician revealed that she felt that she had at times impeded the accuracy of the interpreted interview:

Cl: *"....if I think about that question, I obviously wasn't very clear, and I wasn't brief enough. I also used quite figurative language..."*

Cl: *"That probably wasn't the best interview I've ever done. I think my performance was a confounding variable in this interview, I lost my train of thought, and I was a bit flustered..."*

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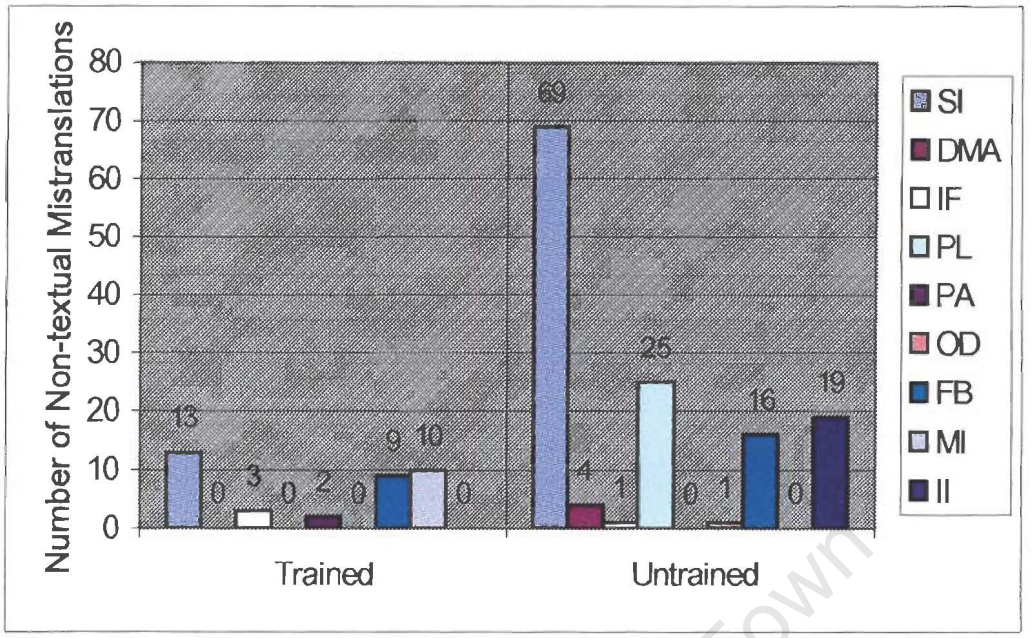
This implies that training the clinician how to work more effectively with interpreters might decrease negative textual mistranslations by the interpreter and make it easier for the interpreter to be as accurate as possible.

Figure 14 examines the possible non-textual causes of negative mistranslations.



Key: SI - Selective Interpretation	PL - Poor Language	FB - Feedback
DMA - Demonstration of Medical Acumen	PA - Poor Attitude	MI - Misinterpretation
IF - Interpreter Fatigue	OD - Outside Distraction	II - Interpreter as Interviewer

Figure 14: Number of Mistranslations According to Non-textual Factors across Trained and Untrained Interpreted Interviews

Figure 14 above indicates that selective interpretation was the largest non-textual cause of negative mistranslations amongst trained and untrained interpreted interviews. However, the untrained interpreters had considerably more occurrences of selective interpretation. The interpreters would selectively interpret what they felt was significant and leave out what they thought was insignificant. This issue is thought to be particularly problematic with untrained interpreters in an initial assessment interview since they are not qualified to make these judgements, having had no training or former experience in the management of speech-language and hearing disorders. It is of utmost importance that the clinician receives all of the case history information from the caregiver to aid her diagnosis and thus plan appropriate rehabilitation. At the same time, it is essential that the caregiver receives all of the diagnostic information from the clinician, so that she understands her child's problems and how they will be helped. The excerpts below reflect the significance of

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omitting crucial information from the clinician's and the caregiver's utterances, possibly affecting the understanding of the informants.

Example 1:

Cl: *"I am going to explain to you what we found in the hearing test today, so that you can know what the results of the hearing test are, and then we can make an appointment for you to see one of the social workers here at the hospital."*

UI1: *"She is going to refer you to a social worker."*

Example 2:

Cg: *"She is improving at school since she is attending there, and now at least I can pick up what she is saying and understand her."*

UI2: *"She is doing fine there, she is doing fine there at school."*

Example 3:

Cg: *"It's her speech, she speaks in short bursts, she is stuttering, plus she does not balance."*

UI2: *"Mmm, the problem is she can't talk properly, mmm."*

Reference has been made in previous research to situations where the interpreter's values and beliefs would inhibit her from being objective in her management of a client (Crawford, 1994). This occurred twice in this study, both times with trained interpreters who felt that caregivers were ignorant with regards to their child's developmental delay. The interpreters struggled to understand how something that was so obvious to them was not apparent to the caregiver of the child concerned. The clinician attempted to indirectly question the caregiver regarding her child's apparent developmental delay, but both times the caregiver was either unwilling to acknowledge that her child had a developmental delay or was truly oblivious of her child's delayed development. In these cases, the

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interpreters would probe the caregivers, more so than the clinician had actually intended in her questioning:

Cl: *"Does he have any other problems besides the speech and the hearing?"*

TI2: *"Is that all that you have noticed wrong with him, the speech and the hearing? Didn't the doctors tell you that he will be slow in developing because he was born early? Is there nothing else that you noticed from him?"*

It is clear from the above excerpt that the interpreter was inserting her ideas into the translation, and probing the caregivers more so than the clinician had intended. These traits were only prevalent amongst the trained interpreters. This was thought to be a way for the trained interpreters to assert their authority in the interpreted interview. Although the trained interpreters are paid and employed as interpreters, interpreters in general are still not acknowledged and appreciated as valuable members of the health care team. If they were acknowledged as being part of a multi-disciplinary team, this might give more credibility to their thoughts and perceptions in a situation such as this. They might not feel the need to assert their authority if they were secure with their status as professional trained interpreters. On the other hand, they might feel that they are entitled to express their opinions, whether the doctor agrees or not. However, Andreyev (1987) makes reference to highly qualified interpreters putting forward their own ideas and states that this can lead to the patient or the doctor being misconceived about the accurate details.

In this study, results from the revised MAT indicated that although at times the trained interpreters would insert their beliefs into the interpretation, poor attitude of the trained and untrained interpreters was not a substantial contributing factor to negative mistranslations. Discussions with interpreters showed that all of the interpreters, trained and untrained, were happy doing the interpreting for the initial assessment interviews. However, the trained interpreters appeared to remain neutral and saw interpreting as part of their job description, while the untrained interpreters were pleased to be providing a constructive service in the interpreted interview. This was also thought to be due to the fact that UI2 and UI3 were unemployed, and the payment they received to do the interpreting was considered an incentive. These perceptions may be explained by Swartz (1998), who expressed that poor interpreter attitude was seen in some untrained hospital

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personnel, because their interpreting services were not remunerated, and were not part of their job description.

Although interpreter attitude was not seen to be a substantial contributing factor to negative mistranslations in this study, it is important to note that Kaufert & Koolage (1984) as well as Wood (1993) have reported that the interpreter's attitude towards the patient, the clinician or the interpreting situation, as well as their ethical position and cultural background can influence the interpretation provided. Other documented factors relating to interpreter attitude which have been reported to cause mistranslations include "laziness" and "carelessness" (Price, 1975), interpreter resistance (Swartz, 1991b) and interpreter frustration or irritation (Swartz, 1998). In addition, dynamics resulting from poor attitude towards interpreting are considered to interfere with the faithlessness of the interpretation and thus could result in tension during the interview (Marcos, 1979).

Poor language or translational skills were the second largest non-textual cause of negative mistranslations within untrained interpreted interviews, while trained interpreters' translations were not as affected by poor language proficiency. Thus, in this study the untrained interpreters' perceived poorer proficiency in expressive English, when compared to the trained interpreters, appeared to largely exacerbate the number of mistranslations. This is in agreement with Drennan (1996a), who stated that difficulties arose more often if the interpreter was not competent in Xhosa and English or Afrikaans. In contrast, Marcos (1979) and Evans (2000) stated that interpreter errors are inevitable, regardless of the level of language competence of the interpreter. It is proposed from the results of this study, that inadequate language proficiency in either of the target languages, can greatly exacerbate the number of mistranslations in an interpreted interview. In consideration of this belief, it is recommended that interpreters are screened for language competency prior to their admission into training programmes, and that interpreter training incorporates enhancement of the target languages. This will be discussed in more detail in Section 4.1.3. The excerpt below reveals the difficulty that one of the untrained interpreter's is having with expressive English.

Cg: *"She doesn't have balance, even if you push her, she just falls down and when she is running, she staggers, then she falls down."*

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UI2: *"She had, had the problem, is she, she doesn't have balance, when she, 'cos she, she's just a little, she fell, fell, ya, fell."*

Individual variation in language proficiency of the trained and untrained interpreters appeared to impact on the number of accurate and inaccurate translations they made. Individual values of accuracy and inaccuracy within trained and untrained interpreted interviews are illustrated in Table 3.2.

Table 3.2: Proportion of Variation of Accurate vs. Inaccurate Translations within Trained (TI) and Untrained (UI) Interpreted Interviews

	TI1	TI2	TI3	UI1	UI2	UI3
Accurate	63%	67%	74%	48%	37%	61%
Inaccurate	37%	33%	26%	52%	63%	39%

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As can be seen in Table 3.2 above, while there is not a great deal of variation between the trained interpreters, there is a large range of variation within the untrained interpreters (37% - 61%). One untrained interpreter (UI3) had a much higher level of accuracy than UI1 and UI2. This was thought to be primarily due to her perceived superior proficiency in English when compared to UI1 and UI2, although innate capabilities were acknowledged as possibly being influential. As was determined through the procedure for selection of informants in this study, UI1 and UI2 appeared to have adequate proficiency in English, however, their level of proficiency appeared to deteriorate during the more taxing task of interpreting. The issue of language proficiency has emerged as an important consideration in this study as a pre-cursor for the selection of interpreters.

An additional non-textual cause of mistranslations was fabrication, which was seen to occur in both trained and untrained interpreters. This was when the interpreter literally added information that was not said by the clinician or the caregiver and in addition appeared to have no positive effect such as increasing understanding. It was thus seen as a negative addition. This was not thought to be a conscious mistranslation but almost a way

of making the question or answer more acceptable or interesting. Smit (1999), examining interpreting services in a hospital pharmacy, stated that elaborations occurred frequently in the untrained interpreted interviews. Elaborations could be correlated with fabrications, since they were said to occur when the interpreters elaborated on their understanding of an original utterance.

Misinterpretations occurred infrequently in this study, and surprisingly only occurred within trained interpreted interviews. This was when the interpreter misunderstood something that the clinician or caregiver said, and relayed the message incorrectly. For example one of the interpreters told a caregiver that her child was hard of hearing in her left ear, when it was actually her right ear, but the interpreter had misunderstood the clinician. This was seen as potentially hazardous, since the clinician was not aware of the misinformation and thus the caregiver was misinformed when she left the interview. The reason that this occurred in trained interpreters only, was thought to be incidental.

The interpreters' demonstration of their own medical acumen was only observed in the untrained interpreted interviews in this study. This was viewed as the interpreter taking over the role of the interviewer or clinician. An example was when the caregiver responded to a question by the clinician, saying that her child's ears were leaking, and the untrained interpreter referred to the 'leaking' as 'white blood corpuscles'. This was clearly an inappropriate use of the term, and was seen to be a negative mistranslation. This occurred several times within the untrained interpreted interviews. It is believed that the untrained interpreters were attempting to use their limited medical knowledge to assist the caregivers to understand. However, the fact that their medical knowledge was limited might have resulted in the mistranslation, which could have potentially affected the clinical management of the patient.

Other times when the interpreter took over the role of the clinician was when they initiated their own questions, either to clarify an answer given by the patient or supposedly to gain additional information that was thought to be crucial. At times, the interpreters would ask questions that were inappropriate, or that the clinician had not asked. Often the clinician was unaware that the interpreter had asked the question, which resulted in her repeating the question to the caregiver, and the caregiver having to repeat the answer. This resulted

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in time wastage and occurred several times with the untrained interpreters, as is indicated below:

Cl: *"Does your child have any other problems?"*

UI1: *"Does he have any other problems, besides the ones you have already mentioned?"*

Cg: *"No."*

UI1: *"Like maybe at home are there no other problems? Maybe is he not growing normally?"*

Cg: *"No there are* [problems]*".*

UI1: *"Like what?"*

Cg: "{Cg crying} *He is not okay where he is staying".*

UI1: *"Where is he staying? Is he staying with his aunt?"*

Cg: *"Yes".*

UI1: *"Like, what is your aunty saying?" ... ...*

This is one example of where the interpreter took over the role of the clinician, and the clinician could not participate due to language barriers. It resulted in uncertainty, since the interpreter could not remember everything the caregiver had said, and thus the caregiver had to repeat answers that were potentially emotionally charged. The clinician reportedly "lost control" of the interview, and felt "helpless" not understanding what had occurred. These findings are contrary to those reported by Kaufert & Koolage (1984), who stated that the clinician has ultimate control over clinical decision-making, but must delegate control to the interpreter in order to establish communication with the client. Thus, the 'role exchange' seen in this study, could be seen as the interpreter taking up some of the

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power traditionally associated with the clinician by taking over their role (Muller, 1994). In addition, Swartz (1991b) proposed that the absence of translation may be read as interpreter resistance. The uneven balance of power is explained in the context of the clinician's professional status being legitimated by a university degree and clinical credentials reflecting a period of academic and clinical training. In contrast, the interpreter's knowledge of an indigenous language and culture conveys power only within the interpreting situation, and is as yet unaccredited as a professional credential. This situation is further complicated by differences in culture between the clinician and the interpreter, where Western medical culture is the culture of power, and the Black or Non-Western culture is disempowered (Crawford, 1994). Despite this, Drennan (1998) states that the interpreter in fact holds considerable power, arising out of being the only party in a triangular interaction who is in a position to understand all that is said, and to selectively convey information without detection by the other interlocutors.

The findings in this study support Launer's (1978), who stated that the use of 'role exchange' by untrained interpreters would result in the patient being asked the same questions again by the doctor, and the interpreter would occasionally irritate the doctor later in the consultation by revealing that he knew the answers to a dozen questions, which he had asked but not translated. In contrast, Vasquez & Javier (1991) as well as Wood (1993) reported that initiation of questions by the interpreter appeared to occur more frequently with the more experienced interpreters, where the lengthy interpreter-patient question-answer sequences remained uninterpreted until their completion when the interpreter would characteristically give a summarised version. It has been suggested that these "interludes" reflect the interpreter's proficiency with the necessary data required for the diagnosis (Launer, 1978). Perhaps where this research differs is that the untrained interpreters in this study were very definitely inexperienced and thus certainly lacked the necessary knowledge that these experienced interpreters possessed.

ii) Causes of Positive Mistranslations

In recent years, research focus has shifted from viewing interpreted interviews solely in a negative light (Price, 1975; Marcos, 1979) to acknowledgement of the social and cultural contribution of the interpreter within the interpreting triad (Kaufert & Koolage, 1984;

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Andreyev, 1987; O'Neil, 1989). The interpreter's function has thus been re-examined and has been defined more along the lines of cultural broker.

Herselman (1994) states that cultural brokerage encompasses adapting the information to the level of the caregiver to facilitate increased understanding. Drennan (1999a) adds that since language is sometimes seen as part of the cultural gap between clinicians and patients, so interpreters are often expected to fulfil the role of cultural brokerage for both parties involved. An interesting question is whether this function of cultural brokerage is a skill that is innate within people of the same culture, or is it refined with specific training? If cultural brokerage requires training, then this crucial function of an interpreter will not be conducted very efficiently or sensitively by untrained interpreters, and if it does not require training, then surely any sufficiently bilingual person could fulfil this role? An attempt will be made to answer these questions in the following discussion.

Factors resulting in positive mistranslations can be divided into two categories, namely attempts to facilitate cultural brokerage and attempts to adjust the content so that it was appropriate to the caregiver's level of understanding. The relative effects of cultural brokerage and attempts to increase understanding were examined and are illustrated in Figure 15 below.

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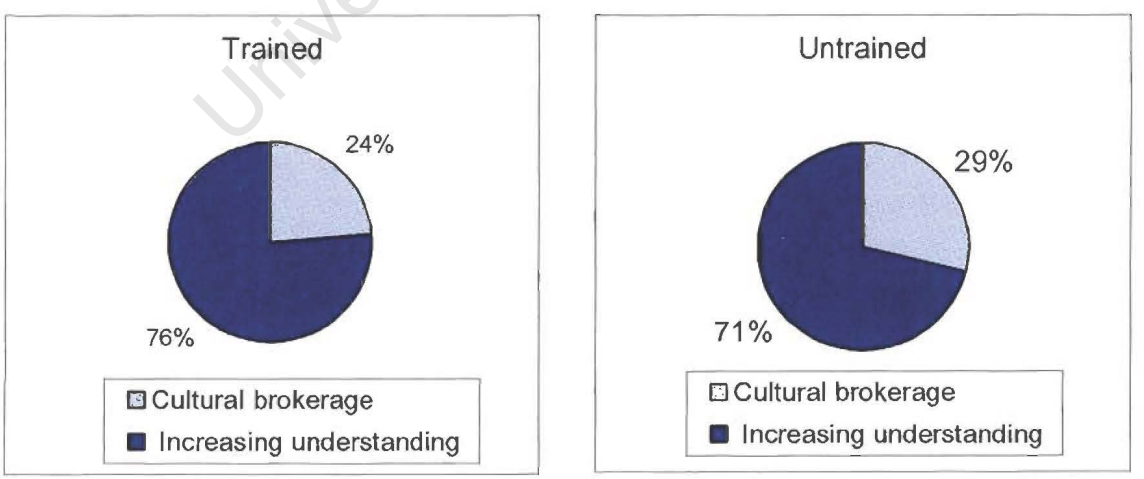

Figure 15: Relative Effects of Cultural Brokerage and Attempts to Increase Understanding as Causes of Positive Mistranslations across Trained and Untrained Interpreted Interviews

The reader is cautioned that although the proportions of cultural brokerage to increased understanding were similar across trained and untrained interpreters, the trained interpreters had considerably more positive mistranslations than the untrained interpreters.

Figure 15 suggests that cultural brokerage occurred to a lesser extent than attempts to adjust the content to facilitate increased understanding, across both trained and untrained interpreted interviews. This is surprising since one might expect the manifestation of more cultural issues when patients describe their symptoms and the causal factors that they attribute to these symptoms. Variation in perceptions of illness have been well documented (Swartz, 1998) and it is for this reason that more examples of cultural brokerage than attempts to increase understanding were expected. However, it appears that the more complex questions asked in the initial assessment interview in this study as well as the fact that the clinician led the interview, facilitated the need for more explanation and expansion of what the clinician said, to encourage caregiver understanding.

The use of culturally appropriate expressions was the most common cause of positive mistranslations within cultural brokerage used by the trained interpreters, while the use of a culturally appropriate analogies or examples was the most common cause of positive mistranslations within cultural brokerage used by the untrained interpreters. These two factors were in fact used most frequently overall to facilitate cultural brokerage, by both groups. One trained interpreter admitted to adding in more culturally relevant examples to assist the caregiver in understanding certain concepts. Use of analogy in the Xhosa culture was seen to increase understanding and consequently, examples were used to illustrate concepts.

TI2: *"I was trying to put more things in a way that she must understand, making examples that she can understand. Hence, I was saying to her, the child is hearing better when he hears a deeper voice than her voice, and even making an example that thing like a bus, because it making a lot of noise, or a dog where he lives, because its barking "woo woo", you know".*

Explanation and expansion of concepts was seen to occur frequently within trained interpreters' mistranslations. One trained interpreter described that exact translation was

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often not possible due to lack of concept equivalents in Xhosa, and consequently expansion or explanation of concepts was considered necessary to increase the caregivers' understanding.

Although expansion of utterances occurred frequently within untrained interpreters, most likely for the same reason as mentioned above, explanation did not. This is thought to be due to their lack of medical and field-specific knowledge, which would prevent them from being able to more easily clarify difficult concepts.

Both trained and untrained interpreters regularly employed strategies such as clarification, as well as repetition and reinforcement of utterances. The trained interpreters tended to use the more common strategy of clarification to ensure that the clinician and the caregiver fully understood her translations. In contrast, the untrained interpreters tended to request clarification when they themselves where not understanding the clinician or the caregiver. The frequent requests for clarification by the untrained interpreters is thus thought to be due to them being unfamiliar with the content covered in the initial assessment interview.

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3.1.1.5 Reasons for Accurate Translations

As mentioned previously, in this study the accurate as well as the inaccurate translations were examined. Although some of the reasons for accurate translations have been previously mentioned in the literature, no researchers have systematically evaluated additional potential reasons for accurate translations, or the strategies employed to facilitate or impair accuracy, and thus have failed to acknowledge the importance of these factors for the development of training guidelines for clinicians and interpreters. Investigation of the reasons for the accurate translations was thought to be useful for training purposes, in that once the interpreter and the clinician are made aware of the reasons for the accurate translations, they will be conscious of employing these strategies to facilitate more accurate transfer of information.

It was believed that a comparison of the accuracies across trained versus untrained interpreters would not be useful, since all the accuracies were clearly positive and this was not the purpose of the accuracy examination.

Following the examination and analysis of the accurate translations, the researcher developed a list of causes for the accurate translations. In accordance with the inaccurate translations, accurate translations were also found to have either a textual or a non-textual basis. Textual factors were those which were considered to be inherent in the text, while non-textual factors were those considered to be external contributors to accurate translations or inherent in the interpreter or clinician. Table 3.3 below, indicates the textual and non-textual reasons for the accurate translations.

Table 3.3: Reasons for Accurate Translations

	Reasons for Accurate Translations
Textual	Introductions
	Biographical information
	Short original utterance
	Grammatically simple utterance
	Proposition at beginning or end of utterance
	Simple terminology
	Simple concept
Non-textual	Good language proficiency
	Good interpreting skills
	Familiarity with terminology
	Prior exposure to the field
	Prior experience interpreting in the field
	Good memory skills
	Sufficient level of sophistication

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It is clear that the textual factors are those which relate largely to the clinician's use of language in the interpreted interview, while the non-textual factors are those which rely on the competency and prior experience of the interpreter. This implies that training guidelines should focus on both increasing clinicians' awareness of the textual factors, as well as improving the competency of the interpreters in non-textual factors.

As Swartz (1998) reported, the skills of the clinician need to be considered, as do the skills of the interpreter. He focused on the responsibility of the clinician to ensure that the interpreted interview was successful and emphasised that the clinician needs to be taught how to work with an interpreter for the consultation to have maximum benefits. Thus, it is

not only the interpreters that need to be trained on how to conduct themselves in interpreted interviews, but clinicians as well.

The most common reasons for accurate translations of a textual nature were when introductory greetings were made, biographical information was obtained, short or grammatically simple sentences were used, simple terminology or concepts were used and when a proposition (meaning unit) was at the beginning or end of a lengthy utterance. These causes were found to facilitate accuracy across trained and untrained interpreters.

According to the clinician and the interpreters in this study, limiting the length of the clinician's utterances facilitated accurate transaction of information. Brevity by the caregiver was also seen to be a factor contributing to increased accuracy, although this cannot be controlled for, since asking the caregiver to shorten her answers might result on the loss of crucial information. One of the trained interpreters admitted to having to cue the clinician at times when she was being too lengthy, which was reportedly appreciated by the clinician:

TI3: *"...what I was doing when she* [the clinician] *is trying to be too long, I look at her and try to cut her in a smart way...because what I am afraid of, is to not take all of what she was saying, because once she says too long sentences, then I won't be able to remember..."*

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The findings from this study are in accordance with those of Ebden et al. (1988), who reported that when clinicians ask serial questions, the (untrained) interpreters tended to concentrate on the last item and to neglect those before. This implies that clinicians should shorten their original utterances. Perhaps one way for the interpreter to overcome the impact of length of utterance, is to take brief notes to remind herself of the important points that the clinician and patient have said. This on the other hand might be too cumbersome or distracting and result in her missing valuable non-verbal information from the caregiver.

Despite lengthy original utterances being one of the primary documented causes of mistranslations, clinicians and doctors often do not take heed of these findings. They appear to continue to use lengthy utterances, which increases the difficulty of translating

accurately for the interpreter. This might be due to the fact that research focusing on identifying these strategies has not been previously undertaken. Therefore, this is another reminder of the importance of training medical professionals who work regularly with interpreters.

It has been reported that technical jargon, anatomical terms and symptoms were more likely to be mistranslated in interpreted interviews, particularly with untrained interpreters without field-specific knowledge (Ebden et al., 1988). This implies that the clinician should attempt to use simple terminology, or use examples to demonstrate complex terminology, when employing an untrained interpreter. If the clinician is unable to use these strategies, it is even more essential that the interpreter be trained in these linguistic aspects and field-specific terminology, to allow them to be more prepared and thus potentially improve the accuracy of the interpreted interview.

Some of the strategies that the clinician noted that she used to facilitate understanding and accuracy were rephrasing and repeating utterances. She used these strategies when she felt that the interpreter or the caregiver did not understand what she had said and attempted to break down utterances into more manageable units, use literal language and slow down her rate of speech. These strategies were thought to work very well by the clinician, as well as the interpreters. The clinician added that she was forced to use these strategies more frequently with the untrained interpreters than with the trained interpreters. These strategies reported by the clinician may indeed be some of the necessary strategies to be adopted by clinicians working with interpreters and thus they should be included in the training of clinicians.

One of the clinician's main concerns and frustrations was that she struggled to determine whether the interpreter was in fact interpreting what she had said accurately. Due to her limited knowledge of Xhosa, she was able to understand some of what the interpreter or caregiver were saying at times but not enough to feel part of the conversations, which she reported made her feel "helpless". One way in which she was able to determine whether information was conveyed accurately was by comparing the length of the original and the translated utterances. In this way, omissions and additions became more obvious. However, this was not thought to be entirely useful, since the interpreter was expected to engage in cultural brokerage and as a result the translated utterances were often more

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likely to be longer than the original utterances. She stated that asking for clarification from the interpreter often assisted her in getting complete information, but that she could not do this too frequently without the possibility of offending the interpreter or appearing condescending. Despite the above-mentioned concerns, the clinician still felt that asking the interpreter for clarification was helpful. These concerns need to be viewed in the light of the existing socio-political situation and considering the influence of past racial tensions, whereby the acts of the clinician could be misconstrued as being racist or elitist.

The presence of more accuracies in the interpreted interviews with trained interpreters is thought to be related to non-textual factors such as their proficiency in English, as well as their experience in interpreting, and exposure to the field of Speech-Language and Hearing Therapy. These non-textual factors have previously been proven to increase the accuracy of the interpreted interview (Launer, 1978; Bal, 1981; Faust & Drickey, 1986; Wood, 1993). Contrastly, the untrained interpreters revealed that they had difficulties expressing themselves competently in English in the interpreted interview, although they thought themselves to be fairly proficient in English prior to the interpreted interview, hence their selection. In addition to this, they had no experience in interpreting or knowledge of the field of Speech-Language and Hearing Therapy, other than their involvement through their hard of hearing children. Once again, this highlights the substantial impact of language proficiency of the interpreters, as well as training interpreters in interpreting skills and field-specific knowledge.

Marcos (1979) believes that proficiency in both languages as well as familiarity with the patient's culture were major requirements for good interpreting practices. According to informants, although cultural differences did not significantly hinder communication between the clinician and the caregivers, poor language proficiency did. This point warrants further discussion. As mentioned above, the trained interpreters were relatively more proficient at English than the untrained interpreters and this significantly affected the understanding of the clinician. In addition, the caregivers also commented that the untrained interpreters often struggled to find a Xhosa equivalent for an English word, so they mixed their languages, which the caregivers found very difficult to follow.

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Cg: *"A trained one would be better because she has been taught, she has been trained in interpreting and...when she transfers information to me from the doctor, she knows that it must be in Xhosa, because she considers that I don't understand well what's being said. So when this untrained one translates for me and mixes English and Xhosa, I do not understand well, that's when I won't know well what was said and I will go home not understanding everything what was said."*

The clinician commented that UI3's difficulty with expressive English often made it difficult for her to get accurate and full information from the caregiver. She felt that the reason that the untrained interpreters often reduced original utterances was because they struggled with a lot of the vocabulary, and thus just left out the words they could not translate directly into English. This is significant, since it may prevent the clinician from making an accurate diagnosis, or from retrieving important medical information from the caregiver. This could in turn affect the future management of the deaf or hard of hearing child, and could potentially result in mismanagement by the clinician. It could also result in caregiver dissatisfaction, in that they may not be getting all the help they need, because the clinician is unaware of certain aspects of the child's condition.

One of the untrained interpreters felt that she had completed a relatively good job (despite the clinician being very unsatisfied with the interview), but did admit that she would have felt more competent had she been more proficient in English. This implies that sufficient proficiency in both languages should be an essential prerequisite requirement of institutions or organisations wanting to train individuals to become effective interpreters. It is recommended that the potential interpreter undergo a formal evaluation of expressive and receptive language proficiency in the languages to be interpreted, since their subjective reports of their language proficiency cannot be relied upon, as was established in this study. We are reminded by Bucci & Baxter (1984 in Wood, 1993) that even speakers who are apparently proficient in the language of the consultation may be feeling insecure, and this feeling of insecurity is exacerbated by limited language proficiency.

Just as language proficiency of the interpreter is proving to be highly important to the success of the interpreted interview, the notion of the clinician's ability to speak Xhosa has been raised. Considering that the clinician in this research felt that she had to a certain extent lost control by being unable to speak the Xhosa language proficiently, increasing

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her working knowledge of Xhosa might in fact empower her and allow for her feelings of control to be restored, without impacting on the interpreter-patient relationship. Crawford (1994) reported that doctors in her study felt that by increasing their knowledge of Xhosa, they had a better chance of knowing whether the interpreter had omitted what they had said or not. In contrast, it is believed that a limited knowledge of Xhosa might be more harmful in that it could result in the clinician misjudging what the caregiver has said. This will be discussed in more detail in Section 4.1.1.

The clinician also acknowledged that she was more comfortable in interpreted interviews with the trained interpreters as opposed to untrained since they were more experienced, had field-specific knowledge to assist in their explanations to the caregivers and were familiar with the strategies used to facilitate understanding and accurate transaction. It should be noted that the trained interpreters used in this study have all had a few years of experience in interpreting and although they were not trained specifically in Speech-Language and Hearing Therapy, they has some exposure to the field, and were thus familiar with the terms and concepts used. This was thought to facilitate transaction to a large extent.

Most of the untrained interpreters were oblivious of purposely using strategies to facilitate transaction, since they were inexperienced at interpreting and had not been given enough time to reflect on such strategies. All of them however acknowledged that training in interpreting would have been useful and they expressed an interest in courses available for such training.

The clinician as well as the interpreters all suggested that pre-discussion interviews prior to the initial assessment interviews between the interpreter and the clinician, should be enforced to prepare both parties for working with the caregiver. In addition, post-interview meetings between the clinician and the interpreter were thought to be essential for the clinician to look for clarification in both the interview material and the dynamics of the interaction, as well as to give the interpreter the opportunity to verbalise and process any feelings that may have been aroused during the interview.

These findings are consistent with recommendations from the literature. Marcos (1979) as well as Swartz (1998) have noted that pre- and post-interview meetings between the

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clinicians and interpreters have been found useful in minimising distortions, such as misdiagnosis of a patient's (mental) status. Evans (2000) reported that briefing sessions between the interpreter and clinician prior to the diagnostic interviews were particularly helpful. Briefing sessions comprised of the clinician discussing the case and the issues that were going to be broached with the interpreter. Wood (1993) suggests that prior to the interview, the clinician should go through any terminology that they anticipate might be problematic with the interpreter, since anatomical and technological terms often prove to be problematic for interpreters. In addition to this, because some issues in the interview situation might be regarded by the interpreter as being embarrassing, they should be forewarned and prepared for such issues (Wood, 1993).

3.1.1.6 Effect of Direction

Considering that all of the interpreters are second language English-speakers, it was speculated that the interpreters might find it easier to translate from English into their mother tongue Xhosa, than from Xhosa into English, which is their second or third language. This is based on the assumption that it might be easier to translate into a language that one is more familiar with. This might be even more so for the untrained interpreters whose proficiency in expressive English during the complex task of interpreting, proved to be poorer than was originally expected.

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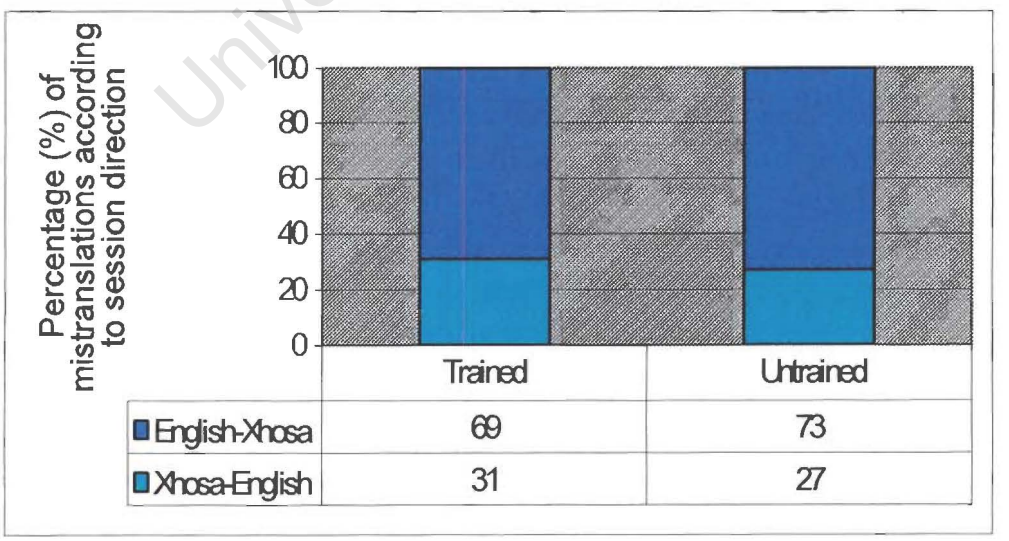

Figure 16: Percentage of Mistranslations According to Session Direction across Trained and Untrained Interpreted Interviews

In contrast, Figure 16 indicates that there were more than double the amount of mistranslations made in the direction from English to Xhosa than from Xhosa to English. This was true across trained and untrained interpreted interviews. This is thought to be due to the fact that the caregivers only spoke when answering questions, and rarely initiated questions. This is in accordance with Muller's (1994) findings, where the patient asked less than one percent of the total questions in the interpreted interview. The fewer questions asked by the caregiver reduced the number of utterances in the direction from Xhosa to English and is possibly why there were fewer mistranslations in this direction. Alternatively, the many mistranslations in the directions of English to Xhosa could also be due to attempts by the interpreters to facilitate cultural brokerage and increase the understanding of the caregivers, since the interpreter might feel the need to explain anatomical terms or difficult concepts that the clinician is using, to the caregiver (Evans, 2000). These findings reinforce that there is often no one-to-one equivalent in English for Xhosa words, and vice versa.

Mishler (1984) mentioned that clinicians control the clinical content of the interview by asking an excess of closed-ended, symptom-orientated questions. According to Gillis et al. (1982), Xhosa-speakers speak in a discursive way and as a result the interrogative style of questioning which is so familiar to Westerners, is foreign to the expectations and practice of most Xhosa-speakers. This is significant as it might indicate that the continuous question-answer format used in traditional case history sessions, might be foreign in terms of style to most Xhosa-speakers. It is in cases such as this where the cultural clinical narrative could be used to bridge these differences. The clinical narrative is a component of "cultural Speech Language Pathology" (Penn, 2000) and is an approach to diagnosis that reflects a sensitivity to cultural and linguistic influences and their interaction with communication disorders. Greenhalgh & Hurwitz (1998), as well as Penn (2000) suggest the use of a clinical narrative, which uses a framework of open-ended questions, as a means of establishing the patient's beliefs and their understanding of their condition. In addition to this, such an approach would facilitate a greater amount of patient-centredness and decrease the power of the clinician. It has also been noted that patients disclose four times the amount of information with open-ended questions as opposed to close-ended questions (Roter & Frankel, 1992 in Muller, 1994).

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In this research, none of the informants mentioned that Xhosa-speaking caregivers might have experienced problems with the format of the session, however, it was very clear to the researcher from the onset that patients did not feel completely comfortable asking questions and mainly spoke when spoken to. This suggests that patient's were almost seen as "invisible" (Muller, 1994, p.6) or as Swartz (1991b) noted, their subjectivity was potentially avoided. Swartz (1991b) reported that patients' political and economic powerlessness and otherness from the dominant White Western norm, determines their ability to be heard. Their silence or clinical inscrutability may facilitate and perpetuate a "veterinary" type of management (Kleinman, 1988). This is thought to be achieved firstly through "the application of a diagnostic system which requires minimal engagement with the patient's own reality" and secondly, through treatment means which "can have effects relatively uninfluenced by the patient's own perspective" (Swartz, 1991b, p.243). Crawford (1994) has linked this to the role of the untrained, unrecognised interpreter, who she claims reproduces the "subjugated" status of the patients "knowledge", "voice" and "stories" (Foucalt, 1983 in Crawford, 1994, p.9). However, it is the researcher's belief that even the use of an experienced, professional trained interpreter could not sufficiently elevate the status of the patient, considering the apartheid history of suppression of the Black people and their languages. There is clearly a vast amount of work that needs to be done to attempt to erase the damage of the past and this research plays a role in highlighting the language needs and particularly the impact of language barriers in health care, for the majority of the South African population.

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3.1.2 Understanding

Suchman & Matthews (1988) have stated that the feeling of being understood by another person is intrinsically therapeutic - it bridges the isolation of illness and helps to restore the sense of connectedness that patients need to feel whole.

Although the use of interpreters is seen to assist the caregiver and the clinician in understanding each other, the introduction of a third party in communication between two parties can in itself lead to miscommunication or misunderstanding (Putsch, 1985). In addition, it is believed that if the interpreter is untrained and thus lacks experience with interpreting, this can lead to even further misunderstanding.

The main findings were interesting in that they revealed that the caregivers and the trained and untrained interpreters always reported that they understood. The interpreters also generally felt that the caregivers understood what they were saying, and thus what the clinician was saying. In contrast, the clinician was the only participant who often did not understand and felt that the caregivers often said they understood when they didn't, particularly with the untrained interpreters, who appeared to be less competent at relaying an accurate message.

It is proposed that these findings should be viewed in the context of differing frames of reference of the informants. It is not surprising that the clinician at times did not understand, considering that she is the only member of the triad who is unable to speak Xhosa. However, during the post interview sessions, the clinician's concerns regarding the understanding of the caregivers was confirmed and thus her inability to speak Xhosa cannot be the only reason for her lack of understanding at times. Furthermore, although the researcher has considered that in any medical consultation, participants come from differing perspectives, the introduction of an interpreter into the usual dyad brings an additional frame of reference to the consultation. In this case, the interpreter is trying to get as much information through from the clinician to the caregiver and vice versa, and thus at times, may not consider that some of the information is not being understood. At the same time, the patient may be overwhelmed at the sheer amount and the content of the information being conveyed and thus may literally be unable to absorb absolutely all of the information in the initial assessment interview or consultation.

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The findings in this study are similar to those of Kline et al. (1980), who reported that patients' and therapists' perceptions were significantly different. Patients interviewed with interpreters felt understood and helped and wanted to return, whereas the therapists responded that patients with interpreters felt less understood and less helped and did not want to return. The therapists consistently underestimated the degree to which the patients felt understood and helped. These authors query whether such misjudgments occur only when therapists work through interpreters.

However, unlike the study completed by Kline et al. (1980), in this study post-interview sessions allowed for levels of understanding to be more carefully reflected upon. Post-interview sessions with the researcher and the caregivers did support the belief that the

caregivers were often confused. When the caregivers were asked if they had any additional questions, they often asked for clarification of certain issues that were discussed in the initial assessment interview, or repeated questions that had already been asked but clearly not answered to their satisfaction or understanding.

In addition, despite the fact that both trained and untrained interpreters reported that they had no difficulties understanding the clinician and the caregivers throughout the interpreted interviews, the findings from the revised MAT, revealed that the untrained interpreters regularly used strategies such as clarification when they were not understanding what the clinician or the caregivers had said. This implies that in spite of the untrained interpreters rectifying their apparent lack of understanding at times, they were clearly not always understanding the clinician and the caregivers.

However, it is logical that the interpreters would always report that they understood, and that they felt the caregivers understood, since admitting that they or the caregivers did not understand at times might reveal inadequacies in their interpreting skills. However, the clinician's comments that she felt the caregivers often did not understand during the untrained interpreted interviews is not necessarily a poor reflection on her, since she correlated lack of understanding of the caregivers with poor expressive language or translation skills of the untrained interpreters.

Of concern is that the caregivers did not admit to not understanding while the confusion was occurring, which prevented the clinician from being able to assist immediately. Since post-interview discussions are not part of a normal initial assessment interview and the caregiver will not always have the opportunity to have issues clarified at a later stage, this implies that the patients or caregivers might leave appointments without a full understanding of their own or their child's illness or disorder, particularly with untrained interpreters. This should be of primary concern to health care professionals, since it intimates that patients are potentially not being managed effectively and often the health care professionals are oblivious of this fact.

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3.2 INTERACTION

Sociolinguists are particularly concerned with the use of language to establish and maintain relationships, as opposed to the use of language purely for the transmission of factual information (Brown & Yule, 1983). This statement clearly distinguishes between interactional and transactional use of language. Previously, few studies have documented how culture and language impact on the interpersonal interaction of the participants of the interpreted interview. Recently, more studies have examined the complex relationships and group dynamics that exist between the clinician, the caregiver and the interpreter within an interpreted interview, particularly considering the unique political history and economic situation in South Africa at present (Crawford, 1994; Muller, 1994; Evans, 2000).

Brown & Yule (1983) note that a great deal of everyday human interaction is characterised by the primarily interpersonal as opposed to the primarily transactional use of language, which has been previously discussed. It is proposed that effective communication through an interpreter is thought to be dependent on a combination of transaction and interaction. As previously mentioned, 'interaction' encompasses all the aspects of how the information is being conveyed in the interpreted interview.

As a result, a number of aspects that emerged within the theme of interaction were discussed, including interpersonal interaction and comfort, non-verbal behaviour, empathy, innate qualities of participants and cultural aspects.

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3.2.1 Interpersonal Interaction and Comfort

The clinician commented that good interpersonal skills of the interpreter are paramount to the success of the interpreted interview and are essential for interpreters working within the field of Speech-Language and Hearing Therapy, which requires a great deal of sensitivity and empathy. The clinician is often expected to relay diagnostic results to caregivers, indicating that their child is hard of hearing, deaf, or developmentally delayed, amongst other diagnoses. When the clinician is working through an interpreter, these situations that can often be emotionally charged, and thus become even more difficult and taxing. Therefore, successful interpersonal interaction within the triad of the clinician, the

interpreter and the caregiver is needed to contribute towards the caregiver's comfort and satisfaction with the interpreted initial assessment interview.

Examination of post-interview discussions indicated that the untrained interpreters always identified more with the caregiver than with the clinician. This was thought to be due to their similar backgrounds with hard of hearing children, as well as similar educational and financial backgrounds. Thus, they could relate more to the caregivers than the clinician.

UI1: *"...this lady* [the caregiver] *is here to tell her problem and she is like me.... I felt like I'm related to this lady, not someone who doesn't know her, like we are now family."*

Contrastly, the trained interpreters felt they could relate more to the clinician, since they both had professional roles. They both work in medical surroundings and have had some experience conducting interpreted interviews within the field of Speech-Language and Hearing Therapy. Despite this, they reported that they sympathised with the caregivers. While the untrained interpreters were concerned about not being condescending to the caregivers or making them feel "inadequate" or "uneducated" because they couldn't speak English well, this did not appear to be of concern to the trained interpreters. This is possibly because the trained interpreters see themselves as members of a team who are employed to assist the caregivers.

Feelings of disconnection between the clinician and the caregivers in interpreted interviews were frequently reported in this study. The clinician felt that even though the interpreter's role was to bridge cultural and linguistic barriers, the use of an interpreter actually prevented the clinician from establishing a relationship between her and the caregiver, particularly since the caregivers spoke primarily to the interpreter and not to the clinician.

CI: *"...and through an interpreter you can't establish that same connection with the caregiver, and the caregiver spoke to the translator as opposed to speaking to me, so that was difficult..."*

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The clinician also reported that she felt an even larger interpersonal barrier with caregivers when untrained interpreters were used, because of the untrained interpreters' over-identification with the caregivers. She felt that there was a complete lack of rapport with caregivers when untrained interpreters were used, while there was partial lack of rapport when trained interpreters were used.

CI: *"... I think because the untrained interpreter and the caregiver had such a close bond, and because they were very close together in this interview, I did feel more distance in this interview situation from the caregiver, and also because what I was saying wasn't getting through correctly. Maybe the mother couldn't identify with me because of that, or couldn't see my use."*

From the above excerpt, it appears that the clinician felt that the caregivers and her interacted differently with each other, when a trained interpreter was used as opposed to an untrained interpreter. She felt less comfortable relating to the caregiver when an untrained interpreter was used because of the reportedly "greater language and cultural barrier" that existed when an untrained interpreter was used, as opposed to a trained interpreter. She attributed this to the limited cultural brokerage skills of the untrained interpreters, as well as her feeling that the utterances that were being relayed to the caregiver from her, were inaccurate. In addition to the presence of a language barrier, it is clear from the above excerpt that the clinician also felt partially alienated from the caregiver due to the close bond that had developed between the untrained interpreter and the caregiver.

The clinician felt that the untrained interpreters and caregivers would often launch into lengthy discussions, excluding her and often making her feel "unwanted" or "unneeded". This occurred less frequently with the trained interpreters, and when it did, they made sure to inform the clinician on the content of the discussion. These interludes between the interpreter and the caregiver appeared to be a way for the interpreter to exert authority over the clinician and take control of the interview. As mentioned previously, Muller (1994) thought that this was a way for the interpreter to even the power balance between herself and the clinician, who is historically the more powerful in the interpreted triad.

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The clinician indicated that she felt slightly more comfortable with the trained interpreters since she had exposure to them before, so she had built a rapport with them prior to the interview, while this was not so with the untrained interpreters.

Cl: *"...Ja, TI3 and I have worked together quite a lot, so we do feel quite comfortable with each other.*

The clinician was also unsure of the competency of the untrained interpreters, and was constantly worried about the accuracy of the interpreted interview with the untrained interpreters, which might have affected her interpersonal interaction with the untrained interpreters. Consequently, she noted that she treated the trained and untrained interpreters differently. She saw the trained interpreters as professionals, and thus treated them in a more formal manner, while she treated the untrained interpreters in an informal manner. She also felt that she reacted to them according to how they responded to her.

Cl: *"I saw the untrained interpreter in quite a different role to the trained interpreter. The trained interpreter looked more professional, and acted more professional, so I treated her in a more formal manner, whereas I treated the untrained interpreter in an informal manner..."*

The caregivers reported that they were comfortable with both the clinician and the trained or untrained interpreter that had assisted them. They also indicated that they saw the clinician and the interpreter as "on the same level". The caregivers also indicated that the clinician and interpreters never made them feel inadequate, and were always kind, polite and warm to them. They were content with the way information was given to them by both parties. This is in accordance with Evan's (2000) findings regarding caregivers' perceptions of comfort with the interpreter and the clinician.

The trained and untrained interpreters thought that the clinician interacted well with all of the caregivers and that they could sense that the caregivers felt comfortable and were not threatened by her as a "White" clinician. Crawford (1994) highlights the profound imbalance of power between clinicians and their patients, where historically bio-medicine reproduces relations of dominance of doctors and subordination of patients. However, in this study, a shift from a bio-medical to a bio-psycho-social model was observed, where

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the clinician adopted a more patient-centred approach. Thus, the clinician in this study, showed an appreciation of and sensitivity towards the cultural and linguistic influences impacting on the interpreted interview and appeared to have made the caregivers feel comfortable throughout the interview. In fact, the adoption of a patient- centred approach, which is not seen as much in other medical consultations, is gaining momentum in many spheres of the profession of speech-language and hearing therapy. It is proposed that the use of interpreters as well as advocating a patient-centred approach is a way of redressing the existing power imbalances between clinicians and patients.

3.2.2 Non-verbal Behaviour

It is not merely language differences that impede cross-cultural communication, but also non-verbal information that can cause additional misunderstanding (Dodd, 1987). Patients and doctors actively engage in interpretation of verbal and non-verbal cues that determine subsequent responses to each other (Erzinger, 1991). In intercultural interactions, non-verbal communication may become even more important because of difficulties and differences in language and culture (Singelis, 1994). When an interpreter is introduced into the interview, the dynamics are even more complex. This is particularly the case if the interpreter does not interpret the essential verbal and non-verbal information to the clinician or the caregiver.

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Singelis (1994) claims that up to 93% of the social meaning of a message is carried via non-verbal channels. Facial expression, body language, tone of voice can all combine to convey a message that is far stronger than the simple verbal message (Singelis, 1994). Research suggests that non-verbal communication is more important in understanding human behaviour than words alone, since the non-verbal channels seem to be more powerful than what people say (Dodd, 1987). Non-verbal communication is thus a fundamental part of intercultural interactions. However, as Dodd (1987) suggests, non-verbal behaviours do not occur in isolation, but rather within a complex communication process.

One of the major difficulties in successfully interpreting non-verbal messages is cultural differences (Singelis, 1994). Just as languages assign different words to carry the same meaning, cultures assign different non-verbal behaviours to carry the same meaning. In

this study, the informants appeared to understand each other's non-verbal behaviours and were aware of the presence of cultural variation in these behaviours. One of the caregivers felt that looking at the clinician and interpreter for non-verbal cues, assisted her in understanding some of what they were saying and in bridging some of the cultural distance.

Cg: *"Because I know little English, some things I could figure out by looking at their eyes, and guess what they were saying..."*

Goodwin (1981, in Muller, 1994) highlighted the importance of eye contact and stated that eye gaze serves as a visual cue to invite and support the interlocutor's speech. Post-session interviews revealed that both the trained and untrained interpreters were comfortable with eye contact, and were able to maintain eye gaze comfortably with the clinician when she was speaking and alternately focus on the caregiver when she was speaking. However, one of the trained interpreters did acknowledge the cultural influence of eye contact, and revealed that training assisted her in using these non-verbal tools appropriately.

TI3: *"The main thing which we are not usually doing as we are Xhosa or Zulu, you don't look someone face to face, it's as if you are undermining that particular person* [if you do]. *For the respect, you are listening, but not looking, but what I got from the training, is to look to that particular person, and read from the lips what she is saying and you will be interpreting well..."*

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Despite the apparent assistance of training in this area, it was felt that the untrained interpreters used appropriate eye contact and felt comfortable with eye contact.

The caregivers on the other hand, although they stated that they were comfortable with eye contact, mostly kept their heads bowed when the clinician was talking to them and did not look at the clinician throughout the interview, but appeared to be comfortable looking at the interpreter. This is in accordance with Muller's (1994) findings, where visual contact was mutually achieved by the patient and the interpreter whilst only being spasmodically achieved by the caregiver and the clinician. The doctor intermittently looked at the

patient, but the patient never looked at the doctor. One of the trained interpreter's reports in this study confirmed these findings:

TI2: *"...and the mother will just look at me, and then if I'm finished, she will look down...so the mother was just looking at me".*

However, the clinician in this study, acknowledging the importance of eye contact in building rapport, regularly attempted to make eye contact with the caregiver, despite the caregiver's lack of eye contact. In addition to this, although the clinician was asking a question that needed to be translated by the interpreter, she would still look at the intended recipient of the information (i.e. the caregiver) when asking the question and she never used the third person when asking the questions. One of the caregivers in this study corroborated these findings:

Cg: *"Yes, I've noticed the doctor looking at me when she was speaking to the interpreter and then the interpreter would look at me to ask me the question..."*

In contrast with these findings, Swartz (1991a) reported that it was extremely rare for the patients in his study to be addressed by the doctor at all, and as Muller (1994) suggested, eye contact after the initial greeting was sporadic, and often not at all maintained by the interviewer. Instead the interviewer tended to address questions to the interpreter, speaking about the patient in the third person.

The clinician also commented that she often used non-verbal cues as communicative strategies, to inform the untrained interpreters that they could commence translation. They would often wait for a signal from the clinician before commencing.

Cl: *"...I couldn't just ask the mom a question directly and then rely on the interpreter to translate immediately. I often landed up having to look at the interpreter, to make sure she would translate what I had said..."*

It thus appears that although culture dictated what was appropriate or inappropriate regarding eye contact, the participants all compensated for this to ensure that all members in the triad were comfortable, which they reportedly were.

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Figure 17 represents the seating arrangements of the informants in this study, during the initial assessment interviews.

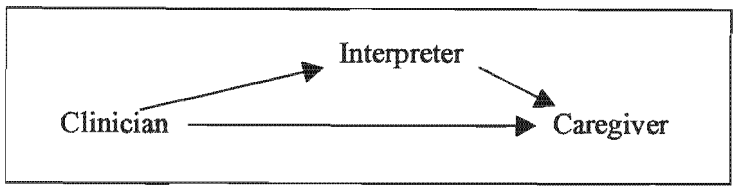

Figure 17: Seating Arrangements During the Initial Assessment Interviews

As can be seen in Figure 17 above, the seating arrangements in this research were that of the interpreter and caregiver sitting closer together and the clinician sitting a little distance away from them. This was to allow the stationary video camera to video the faces of all the informants, but also to allow the interpreter and caregiver to engage directly. According to Penn (2000), the clinician should distance herself slightly from the client and the interpreter should sit closer to the client and engage directly. She adds that this arrangement has the advantage of providing the clinician with an observer advantage and that it indicates a degree of trust on her part. This also shows respect for the cultural gap that exists in such an interview. In addition, the interpreter always sat between the clinician and caregiver, similar to Muller's (1994) positioning of the triad, where the mediatory role of the interpreter was reflected by her seating position. In this study, these seating arrangements in the interpreted interviews were prone to facilitating the easy flow of the interview, and contributed towards unconstrained access of the non-verbal cues of the informants.

The clinician was comfortable with the seating arrangements, except when there was a need for counselling. During counselling, she felt that she needed to sit closer to the caregiver to strengthen the rapport, and to offer comfort or support if necessary. In one case, the mother was clearly upset, and the clinician felt at a disadvantage being at a distance from the caregiver because she could not offer her tactile encouragement or support.

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Cl: *"...the other thing that put me at a distance to her* [the caregiver], *in terms of the counselling, was the seating arrangement, 'cos if I'd been sitting right next to her, then I might've been able to you know, pat her leg or her shoulder or whatever, so let her know I cared, or that I was reaching out to her..."*

This is particularly important, since interpersonal touch has been thought to be one of the most basic and commanding forms of human communicative behaviour (Thayer, 1986). Touch is also integral to interpersonal communication and is imperative to the earliest social attachment bonds (McDaniel & Anderson, 1998).

Observations of the recorded interpreted interviews revealed large differences between the body language of the trained and untrained interpreters. The trained interpreters' body language promoted a more formal interview style. They sat with their arms folded or at their sides, in an upright position in the chair, very seldomly reaching out to touch or comfort the caregiver even when appropriate or expected (e.g. when the caregiver was in emotional distress). Contrastly the untrained interpreters pulled their chairs closer to the caregivers, immediately putting them in a position where they appeared to relate more to the caregiver. In addition, they adopted an informal stance, where their arms were loosely placed on their laps, their body posture was more slumped and relaxed, and they often overly embraced the caregivers, offering support in this way. They portrayed a less professional, but perhaps more empathetic stance, as opposed to the trained interpreters more professional and less interactive stance. The feelings of the clinician supported the researcher's observations:

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Cl: *"I think the trained interpreters definitely looked more professional, and held themselves differently to the untrained interpreters... the untrained interpreters were more casual in their manner and the setup was more informal..."*

The clinician in this study noted the presence of an "imaginary barrier" between her and the caregiver because she was often unable to make sense of their non-verbal behaviours and in addition, these were not being translated to her by the interpreters. Furthermore, this 'imaginary barrier' was exacerbated by the existing linguistic and cultural differences. This was verified by Marcos (1979) who reported that one of the difficulties of using interpreters, was that the formal aspects of thinking and affect (specifically emotional

issues), as well as the sometimes ambivalent attitudes of the patient, were difficult to evaluate, particularly when they were manifested in non-verbal ways. These factors were thought to have a higher probability of being distorted through the interpretation procedure. The main reason for this was that untranslatable paralinguistic and vocal cues were not available to the clinician. Vasquez & Javier (1991) add that this loss of affective information within the interpreted interview, results in an empathetic dislocation (Squier, 1990 in Muller, 1994) or psychological distance between the clinician and the patient.

The caregivers' use of non-verbals to indicate understanding was reportedly confusing to the clinician. The clinician commented that she had noticed on several occasions that the caregivers would nod repetitively when she was talking, as if they were understanding what she was saying. She felt this was disconcerting when immediately after that, they were listening to the interpreter with such intensity that they clearly had not understood what she had said, although they affirmed so.

Cl: *"...when I was giving information, the mom always looked as if she was acknowledging that she was understanding, and she was nodding, but I don't think that she actually was understanding...so it's an important thing to bear in mind if you don't have a translator, or if you're using an untrained interpreter, that it doesn't imply understanding."*

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Diaz-Duque (1982) has emphasised that the interpreter runs the risk of precipitating the "nodding syndrome", if they don't speak in the patient's register (defined as the social or intellectual level at which the language is placed). This occurs when the patient nods in agreement out of fear of embarrassment because he doesn't understand. Health professionals need to be aware of the quick nod since many of the questions they ask patients require "yes" or "no" answers, and an incorrect response could affect management of the patient. Gillis et al. (1982) also commented on patients' affirmation, indicating that it might be a polite cover for non-understanding. In addition, they may offer answers that they feel are more acceptable (Gillis et al., 1982). Bal (1981) suggests that clinicians should avoid asking "yes/no" questions, since these are the first words learnt in a foreign language and will enable the patient to escape without necessarily having understood what you have said. It is also suggested that the clinician monitor the non-verbal behaviours of

the caregivers to look out for any indication of non-understanding, confusion or discomfort.

Bal (1981) added that interpreters who provide only a literal translation of the patient's words may not be as effective as those who take into consideration such non-verbal aspects of communication as nuances, intonation patterns, and facial expressions. These tell their own story, and it is important for everyone involved in the interview to be able to see, as well as hear each other. Interpreters who "act out" their message through intonation, gesture or facial expression, are likely to be more effective in getting their message across (Diaz-Duque, 1982). One of the trained interpreters admitted to often using gesture to facilitate the understanding of the clinicians and the patients in the interpreted interview.

The clinician's non-verbals were also thought to contribute towards the comfort and ease of the caregiver, according to one of the trained interpreters.

TI3: *"...Cl's face was not you know, there are people that you get that will pull faces, and a parent won't feel easy and won't able to say freely all that she wants to say. So Cl's face was a good face to the mama. Hence mama was comfortable and answered what asked of her."*

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3.2.3 Empathy

There is a growing body of criticism of the narrow bio-medical model that has focused attention on the neglect of the central functions of empathy and communication with the patient in the construction of a relationship that can facilitate healing (Kleinman, 1988). Amidst growing concern about the dehumanisation of medical care, there is broad agreement within the medical profession that clinicians should demonstrate empathy and compassion in their interactions with patients (Suchman et al., 1997). DiMatteo & Hays (1980) suggest that an association exists between clinicians' caring and the appropriateness of, effectiveness of, and satisfaction with care. The complex nature of an interpreted interview, including all the internal and external contributing factors, as well as the introduction of an additional member to the dyad, makes the conveyance of empathy in an interpreted interview highly interesting. Within the interpreted interview, there are

additional patterns of cross-communication. This poses the question of whether the interpreters were able to convey their own empathy as well as convey the empathy of the clinician and whether the clinician was able to convey any of her own empathy considering that she was not in direct communicative contact with the caregiver, but had to rely on the interpreter to accurately convey her messages, both verbal and non-verbal.

Morse, Anderson & Botoroff (1992 in Suchman et al., 1997) have identified four components of empathy namely emotive, moral, understanding of the patient's feelings and feedback to the patient. The first two components, emotive and moral, refer to the clinician's intrinsic capacity and motivation to attend to emotional experience of others. Although they are necessary preconditions to empathetic communication in a clinical encounter, the essence of empathetic communication lies in the accurate understanding of the patient's feelings by the clinician and the effective communication of that understanding back to the patient, so that the patient feels understood (Morse, Anderson & Botoroff, 1992 in Suchman et al., 1997). Suchman & Matthews (1988) highlight the importance of the patient feeling understood by another person and suggest that it is intrinsically therapeutic. It is thus clear that empathy and understanding are inextricably linked. This implies that if the caregivers in this research admitted to feeling understood by the interpreters and the clinicians, then it was likely that they felt the empathy being conveyed from both parties to them as well.

From the observations of the initial assessment interviews, it appeared that both trained and untrained interpreters displayed their own empathy towards the caregiver. However, differences were noted. The trained interpreters demonstrated this empathy verbally and in a more controlled fashion, whereas the untrained interpreters demonstrated empathy through non-verbal behaviour. In addition, the trained interpreters maintained a professional distance between themselves and the caregivers, while the untrained interpreters were affectionate and acted more like friends or companions to the caregivers. The findings from the post-interview sessions support the above mentioned observations:

CI: *"Ja, I do think that TI3 was empathetic, and I think she was sort of soft and calm in her approach, but still professional. She wasn't sort of "Ag, shame" to the caregiver, she was professional, but empathetic."*

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TI1: *"Yes, I was feeling very bad for the mother, but you know you mustn't show that in front of the client. You must just be free and ask what the interviewer is asking."*

UI1: *"...I was a bit upset because that lady was, I feel very touched by that lady because she was trying to tell her problem to me, and it was like now I am helping. I am also very emotional and upset."*

All the caregivers reported that the trained and untrained interpreters and the clinician were empathetic and understood how they felt about their child's hearing and/or speech problem or developmental delay.

The clinician expressed her frustration at often not being able to express her empathy directly, owing to the presence of the interpreter. She also commented that she was unconvinced that her empathy was always relayed to the caregivers by the untrained interpreters, more so than the trained interpreters. This was verified by an examination of the results of the revised MAT, which revealed that both the trained and untrained interpreters at times failed to relay emotive content from the clinician, however this was more pronounced in the untrained interpreted interviews. Vasquez & Javier (1991) state that when an interpreter fails to communicate an empathetic expression by the clinician, the resulting lack of response to the empathetic overture may give the impression of rudeness, withdrawal and hostility and perhaps further add to the distortion of the clinical picture. Thus training of interpreters should include an explanation of the importance of conveying verbal and non-verbal empathy from the clinician to the caregiver or patient.

University of Cape Town

Studies examining diagnostic medical interviews showed that frequently when patients brought up emotional topics, the physician would abruptly shift the discussion away from the emotion by changing the topic, generally to resume the diagnostic interview with questions of a bio-medical nature (Suchman et al., 1997). Examination of transcripts from the initial assessment interviews in this study, showed that emotional topics often came up in the interviews from the caregivers. In contrast to the above-mentioned study, the clinician in this research did not ignore the caregivers' emotions, but dealt with them immediately. According to the caregivers, the clinician was thought to display a caring manner of interaction. Caregivers also reported feeling very comfortable with the clinician and they all felt that she was empathetic and supportive. Kleinman (1988)

provides evidence of the positive impact of a caring and respectful attitude towards patients.

It should be noted that there was only one clinician employed in this study and that this particular clinician adopted a more patient-centred approach. However, the researcher is aware of individual variation amongst clinicians or professionals working with interpreters, which in some cases might prevent an interview from running smoothly, or might impact on caregiver and interpreter comfort and satisfaction. This implies that individual variation should be controlled for or measured in future studies of this kind and possibly needs to be examined as a potential contributor to results.

3.2.4 Innate Qualities of Interpreters

Although the issue of training interpreters is of central concern in this study, one cannot ignore individual variation and innate qualities that may enhance or hinder an interpreted consultation.

Within this study, one untrained interpreter (UI3) differed markedly from UI1 and UI2 with regards to the accuracy of translation (See Table 3.2). In addition, her manner of interacting with the caregiver and the clinician reflected good interpersonal interactions skills.

CI: *"There definitely were innate qualities that made her better than the others* [untrained interpreters]. *She* [UI3] *was warm and smiling and bubbly and happy to be here and helping, and somehow I felt she was just more intuitive, but that's just pure luck."*

The clinician also commented that she felt one of the reasons that the caregiver responded so well to this particular untrained interpreter (UI3) was because of her age. She was older than the other interpreters and this was thought to command respect from a cultural perspective. The caregiver was thus more likely to trust her and have faith in her ability, as a respected figure.

Although not considered to be an innate quality, another factor that was thought to contribute to her increased accuracy, was that she had recently undergone an initial

University of Cape Town

assessment interview for her hard of hearing child, and was familiar with the procedure and some of the terminology.

Thus, one cannot ignore that some of the differences between trained and untrained interpreters could result from differences in innate capabilities, as opposed to training in isolation. However, the differences observed in the trained and untrained interpreters interpersonal interaction with the caregivers, implies that training might dampen some of the interpreters' natural instincts or emotions and make them more like 'machines' than humans. In addition, it appears that there are certain interpersonal skills, such as the display of empathy, that make an interpreter better able to interact effectively with patients, which cannot be taught. This implies that there should be certain prerequisite requirements and screening of individuals wanting to become interpreters, and that training alone is not sufficient to equip a person to be a good interpreter.

These findings support previous research conducted by Johnson, Noble, Matthews & Aguilar (1999) that interpreters working in health care showed disparate levels of competence in interpretation, due to a combination of factors such as varying levels of training and innate capabilities. This variability in the interpretation of health care information was thought to profoundly influence the health care encounter and the consequences of the care.

University of Cape Town

3.2.5 Cultural Issues

Culture is defined by Helman (1996) as "a set of guidelines which an individual inherits as a member of a particular society, and which tell him how to view the world, and how to behave in it in relation to other people, to supernatural forces or gods and to the natural environment" (Helman, 1996, p.2). It is clearly a quality that is amassed throughout one's life or inherited and not one that is easily learnt by someone from another culture.

Erzinger (1991) states that patients and doctors interpret cues based on a "scaffolding of culturally determined beliefs and values that are reflected in their interactional behaviour" (Erzinger, 1991, p. 91). The interactional style or manner and the cultural rules underlying how patients and doctors respond to each other determine the course of their communication in the medical encounter.

Doctors and their patients, even if they come from the same cultural background, view ill-health in different ways. Their perspectives are based on different premises, they employ a different system of proof and assess the efficacy of treatment in different ways (Helman, 1996). If one considers that one of the roles of an interpreter is to bridge the cultural divide, how does their cultural orientation impact on their management of the interpreted interview? Interpreters, who are likely to have the same cultural background and beliefs as the caregivers or patients they are interpreting for, have in addition possibly been trained within a bio-medical model, to familiarise them with the beliefs of Western culture. Reference has previously been made to the differences between a bio-medical and a bio-psycho-social model of treatment. These conflicting models, as well as the unequal balance of power between doctors and patients in the interpreted interview might cause the interpreter a great deal of internal dissension.

Although one might have expected cultural differences between the clinician and the caregivers to impact on the initial assessment interviews, both trained and untrained interpreters reported that differences in culture between the caregivers and the clinician did not impact significantly on the interpreted interview. Furthermore, they felt that their own presence facilitated understanding between both parties, and thus misunderstandings as a result of cultural differences did not occur. This would imply that they successfully mastered their role as cultural brokers, which will be discussed in-depth in Section 3.5.

However, one of the untrained interpreters did explain that it is common in the Xhosa culture to not bother your parents or family members with your problems, since they are respected figures and thus one should try and solve the problem first before going to them. This was in response to a caregiver who was very upset about the abuse of her child from one of her aunts who looks after her son during the day when the caregiver works.

UI1: *"...if you have a problem you don't go to your mother first, you go straight to your close friend and then maybe she can do something...the great person like your mother, your father, you don't speak a lot to them....I think it's something like respect, you mustn't speak a lot what is happening in your life...it's like a respect."*

University of Cape Town

She explained further that she felt if the clinician was Black, the caregiver might actually not feel comfortable telling the clinician her problems, and might not tell her everything in case the Black clinician might report back to her family in some way. She might have assumed that a Black clinician might have ties to her community, by virtue of her race and culture. As a result, the Black clinician could potentially jeopardise her position in the community by informing her family or friends of her problems, when she clearly does not want them to know. The caregiver also added that she felt comfortable with the clinician and trusted her and that she felt the clinician would "not take the problem outside", but assist her and "deal with the problem inside". The clinician did in fact refer the caregiver to a Black social worker at the hospital, for assistance.

Trained interpreters thought that the clinician was culturally appropriate and that the caregivers could sense this and as a result weren't ever offended, and felt comfortable with the clinician. Untrained interpreters also thought that the clinician was culturally appropriate, but most did not realise the impact of cultural differences on the interpreted interview.

From the clinician's perspective, a greater cultural divide between herself and the caregiver was noted when using untrained interpreters, since they often excluded her from conversation and failed to inform her about what the caregiver had reported.

Cl: *"I definitely did feel at more of a disadvantage today, because so much information was lost through the untrained interpreter, and the cultural divide was highlighted so much that I really, really wanted to be able to speak the language or have a trained interpreter there with me."*

This implies that training in cultural brokerage as well as an appreciation and acknowledgement of the differences between cultures might have been useful for the untrained interpreter, and thus should form a core component in the training of interpreters.

Communication and culture reciprocally influence each other. The culture in which individuals are socialised influences the way they communicate and the way that individuals communicate can change the culture they share over time (Gudykunst, 1997).

University of Cape Town

Erzinger (1991) adds that interpretation of verbal and non-verbal cues by patients and doctors are culturally defined and determine subsequent responses to each other. It makes sense then to assume that the differing backgrounds of the clinician and the caregivers might result in misinterpretation of non-verbal cues or responses. The clinician thought this did not occur because she was familiar with some of the cultural differences between her and the caregivers and thus knew what to expect and how to manage such situations. One example would be understanding that most caregivers would not feel comfortable maintaining continuous eye contact with her. She anticipated this and as a result did not feel offended, although she did report that it made building rapport with the caregivers very difficult.

3.3 NEED FOR INTERPRETERS IN HEALTH CARE

The need for interpreters in health care has been clearly established in previous research (Swartz, 1991a; Drennan, 1992; Crawford, 1994, 1999; Drennan, 1996, 1998; Swartz, 1996, 1998; Erasmus, 1999). In this study, the need for interpreters in health care in the Western Cape was established through post-interview discussions with informants about existing interpreting arrangements, the relative merits or demerits of consultations with and without interpreters present, as well as their impressions on previous use of interpreters. Furthermore, their experience with trained and untrained interpreters was examined.

University of Cape Town

All informants in this study confirmed the need for interpreters in health care. Patients speaking indigenous languages are seen to be most affected by the current economic dispensation and past historical discrimination, which as a result has appeared to influence their quality of care and medical management at community-based clinics, as well as tertiary health care institutions. One of the caregivers highlighted the presence of language barriers in hospitals and the resultant difficulties arising from that.

Cg: *"...if the interpreting business can go as far as all the hospitals, you will see it really is helpful for us, because many of us can't speak the language* [i.e. English], *especially those coming from the Transkei, they don't even know a word in Afrikaans and we always need help in the hospitals..."*

The caregiver also reported that her very limited proficiency in English prevented her from being able to communicate effectively with the White clinicians in hospitals, and as a result, another Xhosa-speaking person in the hospital was called to assist. This ranged from hospital personnel, such as nurses or cleaners, to family members or other patients waiting in the waiting room that were reportedly 'bilingual'. There were also times where such 'bilingual people' were not available and the caregiver had to make use of her limited understanding of English to get assistance for herself or her child. This confers with the existing 'ad hoc' or haphazard interpreting practices that have been repeatedly reported in health care institutions in South Africa (Crawford, 1994; Muller, 1994; Drennan, 1998; Swartz, 1998; Erasmus, 1999). The findings from this study are also in agreement with Hirschowitz & Orkin (1995 in Swartz, 1998), who reported that Xhosa-speaking patients were shown to have the greatest difficulty accessing health services and were not managed efficiently when they did. Clinicians spent less time with Xhosa-speaking patients than other patients and frequently only minimal details are obtained from them (Hirschowitz & Orkin, 1995 in Swartz, 1998). Research suggests that perhaps the greatest need for interpreters is in the health services (Erasmus, 1999).

One of the caregivers felt that if there had been no interpreter, she would not have received the help she needed for her child, because the health care professionals would not have understood her or her needs. The post-interview sessions with the caregivers revealed that all of them felt that their needs had been met with the use of the interpreters, despite the varying degree of accuracy and other differences between trained and untrained interpreters.

Cg: *"...without her* [the interpreter], *I don't think I would have been helped as fast or gotten all the information about my child..."*

Some of the caregivers also reported that even though they felt that they could understand some English, they still struggled when no interpreter was available to interpret for them. This resulted in the caregivers missing a lot of what was said, or asked by the doctor and feeling that they might project an image of being "stupid", when in actual fact they couldn't understand what the doctor was saying. One of the caregivers commented on her experience without an interpreter:

University of Cape Town

Cg: *"...there was no communication between me and the doctor, because in some places I just get stuck in English. I tried to catch up, but didn't get all what she was saying, but there was no other way that day. The doctor didn't understood me either."*

The caregiver also acknowledged that the doctor would have struggled to understand her as well, because of her very limited ability to speak English. Thus, the need for interpreters in health care is essential to assist the patient in understanding their problem, as well as allowing the doctor to appropriately manage and understand the patient.

One of the interpreters poignantly summed up a common situation for Xhosa-speaking patients in health care institutions in the Western Cape:

TI3: *"...when the mum arrived at the hospital, she didn't know where to go, they pushed a file in her hand and said "Listen lady, go to...", and she can't understand them, and she can't communicate with any other person she meets in the passage and ask them "Where must I go?", because she can't speak the language..."*

University of Cape Town

One of the trained interpreters expressed her concern that so many Xhosa-speaking people are not getting helped at hospitals because of lack of interpreters to assist communication between health care providers and patients. She explained that patients are often told to come back again and given another date because no one can speak their language. Similarly, patients often leave hospitals following uninterpreted appointments with doctors, not understanding exactly what they were told by the doctor. This results in what appears to be non-compliance by the patient, but actually is a result of misunderstanding, due to language barriers and a lack of interpreter services.

Similarly, Drennan (1996a) noted that some of the implications for not providing adequate language services in health care was that clinicians reported that often important collateral information could not be obtained, and thus there was diagnostic uncertainty on important questions related to the health of the patient. Patient management would thus begin under conditions of poor clinician-patient communication and the diagnostic uncertainty also resulted in poor compliance and an increased likelihood of relapse and readmission. This

places an additional burden on health services and the community as a whole. These situations arose when the interpreter was not competent in Xhosa or English and had no field-specific knowledge or training.

All three of the trained interpreters in this study acknowledged the need for additional interpreters in health care. Two of the trained interpreters in this study working at a paediatric hospital, reported that even though they were both employed at the hospital, there was still a need for additional interpreters because many times they could not cover the growing need. They reported that the result of this is that when they are unavailable, nurses and other staff members are used as interpreters. This is in accordance with the above-mentioned comments from the caregivers on the existing 'ad hoc' interpreting practices.

One of the caregivers reported that she has had experiences of nurses interpreting for her several times. She felt uneasy with nurses interpreting, since she felt that they were rushed and had to get back to their work in the hospital, instead of helping her. She also commented that she preferred the interview with the trained interpreter at the centre-based clinic, because she was not tired or rushed. Taking time with patients and acting in an unhurried manner has been reported as a crucial skill in cultural brokerage, allowing the patient to be comfortable (Herselman, 1994). This is also more in line with a patient-centred approach, which is slowly gaining recognition in place of the traditional medical model, as previously mentioned.

University of Cape Town

Cg: *"...the one helping me was a nurse from the hospital, but I preferred the one from today, because she was not tired or rushed."*

The use of nurses as interpreters has been fairly extensively researched and raises numerous contentious issues. Nurses are very frequently used to facilitate cultural brokerage and understanding between linguistically divergent health care professionals and patients, due to the lack of available interpreters, amongst other things (Crawford, 1994; Muller, 1994; Herselman, 1994; Drennan, 1996a, 1998; Elderkin-Thompson et al., 2001). It is reportedly a litigious issue that nurses are taken away from their duties, which are already overloaded, in order to interpret. Drennan (1996) reported that nurses often resent the imposition of an 'unofficial' task for which they are untrained, unappreciated

and unrewarded. In addition, Herselman (1994) noted that nurses do not see it as part of their duty, and that they don't always communicate effectively with the patients. In addition to this, clinicians reported that they resented wasting time tracking down a willing nurse to interpret for them. It is clear that the absence of an interpreter creates a significant organisational burden, not to mention the client who is being denied access to professional, confidential assessment by a qualified person. Herselman (1994) suggests that in order to address this immediate concern, and considering that the lack of sufficient language services is unlikely to resolve in the near future, cultural brokerage should become a formal aspect of the training of nurses involved in multicultural health care situations. She concludes that it should be officially defined as part of a nurse's role and included in their job description. Contrary to Herselman's (1994) suggestions, the researcher proposes that the focus should be on transforming the health services through policy formation that allows for the employment of professional trained interpreters to act as cultural brokers or mediators and thereby more effectively and efficiently facilitate communication between clinicians and their patients.

Furthermore, it has been reported that clinicians would assume that because nurses often spoke the same language as the patient, they would automatically have the counselling and communicative skills to put across sensitive or difficult messages or give bad news. The nurses reportedly found this enormously stressful (Crawford, 1994). This implies that training in these skills is necessary to be an effective interpreter, whether it is a nurse that is doing the interpreting or a professional interpreter. Johnson et al. (1999) state that the demand for interpreter services to meet the growing need for effective communication within the health services is increasing, and lack of available trained interpreters leads to inappropriate practices.

In addition to the need for interpreters being acknowledged by informants, an even greater need arose - the need for trained interpreters.

Cg: *"I definitely needed an interpreter, I might be okay here and there, but this interpreter* (UI1)*, she was interpreting in a strange way, that I didn't always understand what she was saying..."*

University of Cape Town

Cg: *"I want to say that it is very important that you get trained interpreters for us, so that they can do their best, because the fact that we say we can't speak English, that needs a person who is trained to do the job, instead of going out here not satisfied and not understanding, because they used an untrained one."*

TI1: *"...now that we're there, there is a big difference now, because if there was no trained interpreters, people would really suffer, but there is somebody to help now..."*

Cl: *"I felt a lot more competent in the interview situation today with the trained interpreter. I could communicate and interact much better with the caregiver today, than when I was using the untrained interpreter."*

The fact that the clinician commented that she "felt more competent" using a trained interpreter and that the caregivers feel more understood and acknowledged, is an important finding, since it implies that training of interpreters might not only result in the empowerment of the interpreter, but it also empowers the clinicians and patients involved in an interpreted consultation.

Thus, analysis of the post-interview discussions revealed that all of the informants preferred trained to untrained interpreters. A number of negative consequences of using untrained interpreters emerged from all informants, while in contrast, a number of positive consequences of using trained interpreters were raised. These consequences and reports are considered as motivating factors for the creation of full-time posts for interpreters within community clinics, as well as all tertiary institutions. In addition, these interpreters should be expected to undergo training as a prerequisite factor for employment. Findings from this research are consistent with those from past research suggesting that there is a dire need for full-time, trained interpreters to ensure that all patients are receiving appropriate healthcare, in their language of choice.

University of Cape Town

3.4 ROLES OF THE INTERPRETER

Several researchers have focused on the multiple and occasionally conflicting roles that are expected of interpreters within an institutional context (Kaufert & Koolage, 1984; Crawford, 1994; Kaufert & Putsch, 1997; Drennan, 1998; Swartz, 1998). Drennan (1998) acknowledges that interpreters are invariably subject to the stresses attendant on fulfilling a function for which there is a lack of definition. It is suspected that this is one of the reasons why all of the interpreters in Marcos' (1979) study felt overwhelmed by the responsibility of serving as interpreters.

In this study, the roles of the interpreter emerged as a prominent theme. These are described according to the differing perceptions of the informants, as well as what has previously been documented in the literature.

i) Interpreter as a 'Linguist'

In this study, the focus has not been on the role of the interpreter as a 'linguist', since mistranslations were not merely seen as being *errors*, but were acknowledged as being opportunities for the interpreter to assist the clinician and the caregiver in a number of ways. Although the clinician did see the interpreter's role to be partially that of a 'linguist' in terms of the relay of information between herself and the caregiver, she primarily emphasised the importance of the interpreter facilitating cultural brokerage between herself and the caregivers, throughout the interpreted interviews. Thus the clinician has acknowledged that the interpreter's role extends beyond someone who provides the correct words, in keeping with the hermeneutic approach proposed by Swartz (1998).

In contrast, Crawford (1994) reported that doctors in her study were using the model of the interpreter as a linguist within an empiricist approach (Swartz, 1998). This is a common perception of an interpreter's role, where the interpreter is seen almost as "invisible" (Swartz, 1998). This has been equated with the "black box" model of interpreting, where the interpreter is seen as a channel for the transformation of meanings from one linguistic system to another, without an appreciation of crossing cultural boundaries, where there is

University of Cape Town

not necessarily equivalence between the cultural constructs and the ways of perceiving the world (Westermeyer, 1990).

It is proposed that the differences in the perceptions of the clinician in this study and the doctors in Crawford's (1994) study could be related to the clinician in this study having an appreciation of the complexity of the interpreting situation, which contributed towards an understanding that the duty of the interpreter extends beyond that of mere translation.

Furthermore, this model of interpreting is thought to be inappropriate in a medical context, considering that medical terminology and concepts are often not directly translatable into another language, and the same might apply to the patient's conceptualisation of the disease process.

ii) Interpreter as a 'Cultural Broker'

The clinician viewed the interpreter primarily as a cultural broker, whose role was to assist the clinician in making assessments of the patient's beliefs, and explain to the clinician the context and meaning of aspects of the patient's life, of which the clinician could not possibly have any knowledge (Swartz, 1998). Furthermore, the clinician in this study acknowledged the complexity and intricacy of the interpreting situation. She suggested that a multitude of factors impacted on the interpreted interview, such as cultural, educational, socio-economic and political influences as well as a number of inherent differences between the members of the interpreting triad. This is in direct contrast to Crawford's (1999) findings, where doctors often did not appreciate the difficulties of the interpreter's role. Interpreting was seen as "a simple value-free rendering of the same message in a different language" (Crawford, 1999, pg. 35). This view is more in line with the interpreter fulfilling the role of a 'linguist', as previously mentioned.

Furthermore the clinician recognised that the role of cultural brokerage includes culturally appropriate explanations to the clinician as well as the caregiver. The clinician indicated that she relied on the interpreter for cues to allow her to practice in a more culturally appropriate manner with the caregiver, and she also assumed that the interpreter would explain responses from the caregiver that were complex due to cultural influences. This is in accordance with Kaufert & Koolage (1984), who state that cultural brokerage involves

University of Cape Town

providing explanations of indigenous cultural beliefs to clinicians, as well as explaining aspects of medical culture to patients.

The trained interpreters primarily saw their role as helping the clinician and the caregiver breach the linguistic and cultural divide. Implicit in this was a need to ensure that both the caregiver and the clinician understood each other completely and felt comfortable during the interpreted interview.

TI3: *"... because I made the clinician understand what was happening and I made a mother ...feel easy and relaxed, because there's somebody who is going to talk all what she's not understanding and hearing properly"*

In a sense, the interpreter here sees herself as a cultural broker for the clinician and the caregiver, as well as a patient advocate, which will be discussed below.

Studies have shown that there are unrealistically high expectations of the cultural brokerage role of the interpreter (Drennan, 1998). In this study, the interpreter's role was to actively mediate and negotiate between two different conceptual systems, that of the clinician and the patient. As cultural brokers, interpreters are expected to link their knowledge of health care procedures and human physiology with parallel knowledge of indigenous language and culture. As Swartz (1998) suggests, it is not realistic to expect any interpreter to fully understand the cultural background of every person the clinician deals with, but a person who speaks the client's language is likely to know more about the client's cultural background, than the clinician who cannot converse with the client. Clearly cultural brokerage has emerged as a complex task requiring a great deal of skill from interpreters. Thus, it is suggested that interpreters receive adequate training in strategies for effective cultural brokering.

iii) Interpreter as a 'Patient Advocate'

It has been documented that clinical encounters can often be a bewildering experience for patients, particularly if they cannot communicate with the health care staff (Drennan, 1999a). Advocacy is considered necessary for patients with different cultures and languages than the professionals that are assisting them. Advocacy models of interpreting

University of Cape Town

vary from the interpreter acting as a social worker or lay psychologist to the interpreter being part of a 'professional team' (Erasmus, 1999). This model of interpreting is also sometimes known as the 'community interpreting' approach, because of the emphasis on community needs and questions of power relationships across communities. Erasmus (1999) believes that the advocacy approach can only work within a very supportive organisation or interpreting service. Indeed, it is proposed that interpreter support is crucial to ensuring a positive interpreting outcome.

Although the untrained interpreters acknowledged their role in assisting the clinician to understand the caregiver, they felt their most important role was helping the caregiver feel comfortable. They saw themselves as 'advocates' or 'spokespeople' for the caregivers, which mirrors the impressions of the caregivers' perceptions of their role. One untrained interpreter felt that she enabled the caregiver to have her voice heard, and felt that without her assistance, the caregiver would have had to 'bottle up' all her feelings for concern at lack of being understood. Thus their role was to assist caregivers to express all their feelings and anxieties or concerns and could be seen as that of patient advocacy.

The above-mentioned findings that the untrained interpreters feel they function as the voice of the caregiver, was consistent with those findings reported by Crawford (1994) Muller (1994). Crawford (1994) asserted that the interpreter reproduces the subjugated status of the patient's knowledge, voice and stories. However, she felt that with an untrained interpreter, the input provided was not enabling of the patient's voice. This is in contrast to the findings in this research, since the caregivers felt that both trained and untrained interpreters were able to represent their needs and relay their sentiments and information accurately to the clinician. This is significant, since it implies that the employment of interpreters in health care may be seen as a means of providing the patient with a voice in clinical assessment. The interpreter's role then is to assist the client with access to resources and essentially empower them. Thus, the inclusion of the advocacy role in interpreting work could be seen as an attempt to address the relations of power that have formed around exclusion on the basis of language.

The perceptions of the caregivers regarding the role of the interpreter, were in accordance with the views of the untrained interpreters. The caregivers simply felt that the interpreters were there to assist them, because they were able to communicate with them in their own

University of Cape Town

language. They were unconcerned that the clinician could not speak Xhosa because they felt they were being represented by the interpreters, who were able to "speak for them". Thus they viewed the interpreters as patient advocates.

Cg: *"She was here to help me because she was explaining to me in my own language and then speaking for me to the doctor."*

One of the caregivers expressed much surprise that the interpreter was present to help the clinician as well, since she saw the interpreter's role purely as a patient advocate. She stated that she was also initially surprised at the choice of interpreter, a woman who also had a child who was hard of hearing, and was clearly not qualified to be an interpreter.

Cg: *"I was shocked with the one who was going to be a translator, more specifically that she was also here to help the doctor"*

The researcher believes that situations such as these could be avoided by the consistent and organised presence of well-qualified trained interpreters, as well as the elimination of 'ad hoc' interpreting practices in medical institutions.

iv) Interpreter as an 'Interviewer'

The clinician felt that there were many times when the untrained interpreter would take over her role, and act as an independent interviewer. This has been previously discussed in the "Accuracy" section of this study (Section 3.1.1.5), and was seen to have a negative impact on the interview. It resulted in the clinician feeling a loss of control during the interview, and not being fully informed about the caregiver's responses. It was proposed by the researcher that this was because the untrained interpreters were not necessarily proficient with the necessary data. Vasquez & Javier (1991) described this as occurring when an interpreter takes over the interaction and replaces the interviewer's questions with the interpreter's own, thus assuming the role of interpreter. It has been suggested that this "role exchange" could be seen as the interpreter taking up some of the power traditionally associated with the clinician by taking over their role (Muller, 1994).

University of Cape Town

Penn (2000) presents a counter argument to this view, and suggests that the interpreter should be seen as a valued and respected member of the health care team and thus should be given autonomy to act in a way that she feels is appropriate. Furthermore, Penn (2000) suggests that the clinician should allow the interpreter to sit closer to the patient, and engage directly with the patient. She recommends the initiation of a period of flow-talk between the interpreter and the patient, where not everything needs to be translated. This implies that the clinician has a certain degree of trust in the interpreter. It is proposed by the researcher that such a situation could only occur on a regular basis once interpreters in general are trained, professionalised and indeed valued as members of the health care team.

v) Interpreter as a 'Member of a Team'

The clinician in this study regarded the trained interpreters as valued members of the health care team. She acknowledged that the presence of trained interpreters allowed her to perform her duties efficiently and effectively, as opposed to the use of untrained interpreters, where this was not always the case. This was primarily due to the untrained interpreters' lack of experience within the field of Speech-Language and Hearing Therapy. The clinician felt that she could not completely rely on the untrained interpreters to relay all the necessary information to enable her to manage the caregiver and child effectively, since they often could not distinguish which details were important for diagnosis and management purposes. However, the trained interpreters, all of whom had had some exposure to the field of Speech-Language and Hearing Therapy, were more easily able to distinguish between irrelevant and relevant information.

University of Cape Town

Wood (1993) proposes that this model of partnership is ideal, since both the clinician and the interpreter have specialised knowledge to offer the patient and thus functioning as a team, will allow the patient to receive optimal care. A team approach would require valuing the unique skills and insight of the interpreter and entails working in a more equal way with the clinician to construct a more sensitive and detailed picture of a patient's condition. In addition, a more patient-centred approach within a bio-psycho-social model is advocated, as opposed to the traditional doctor-centred approach and implicit in it is an openness and commitment to really listen to what the patient is saying. However as mentioned previously, it is proposed that viewing the interpreter as a team member can

only occur with serious re-negotiation of the interpreter's role and status as a valued member of the health care team, rather than a subordinate. Training and professionalisation of interpreters is believed necessary to increase their status and solidify their position as an important member of the health care team. This will be discussed further in Section 4.1.3.

vi) Interpreter as an 'Assistant'

One of the trained interpreters saw herself as an 'assistant' to the clinician, because she was assisting her in making a diagnosis. This could be likened to the role of 'junior clinician" where the more experienced interpreter is expected to interpret the significance of the patient's utterance and this is thought to be dependent on the interpreter's application of clinical skills and insights (Drennan, 1998). Swartz (1998) adds that viewing the interpreter as a 'junior colleague' involves recognising the skills a good interpreter brings to the interview and using these skills in a team approach, where the interpreter's opinions form part of the team judgement about the client. However, it is suggested that viewing the interpreter as a 'junior clinician' is essentially patronising and consequently does not acknowledge the unique and essential skills that interpreters bring to the interpreted interview. Thus, it is proposed that perhaps in this light, viewing the interpreter as an equal member of the health care team, as opposed to a 'junior colleague' might be more appropriate.

In addition, it should be noted that although experienced, trained interpreters might be able to act in this role, not all interpreters have sufficient clinical background to deal with this expectation. This implies that if an institution is expecting an interpreter to act as an equal and important member of the health care team, the interpreter needs field-specific training to be able to make accurate judgement calls.

vii) Interpreter as a 'Supporter'

During the post-interview sessions, the interpreters frequently referred to themselves as 'supporters' to the caregiver. This further solidifies the interpreter's role as assisting the caregiver. In this study, the role of 'patient advocate' and that of 'supporter' are differentiated in that the role of 'supporter' is not affiliated with empowering the client as

University of Cape Town

patient advocacy does, but is rather a role of emotional support and sensitivity towards the caregiver.

The untrained interpreters generally felt that they should sit closer to the caregivers since their role was to provide the caregivers with support and encouragement. In addition, one of the untrained interpreters mentioned that she did not want the caregiver to see her status as elevated because she was interpreting for the caregiver. She was very conscious of acting like a 'normal person', and not appearing condescending or as if she 'knew more than the mother' because of her better proficiency in English. Her primary concern was to ensure that the caregiver was comfortable.

A trained interpreter in this study, although acknowledging the need for assisting the clinician, saw her role as offering support to the caregiver in terms of counselling. The particular interview required counselling and sensitivity, since the caregiver's child was developmentally delayed. The caregiver did not seem to realise the future repercussions of this and thus the interview was emotionally charged. The interpreter felt that she was a help to the caregiver because the caregiver was able to have her language expressed, as well as the fact that she had support from someone of the same cultural and linguistic background. Her role would thus be one of a cultural broker as well as a supporter to the patient.

University of Cape Town

There was general consensus amongst the untrained interpreters, primarily of pride at making a contribution to society by assisting and supporting those in need. They all used adjectives such as 'happy', 'proud', 'enjoy', 'great', 'nice' and 'good'. They were seen to be exceptionally willing to help, and give of their time, and felt it was an honour to be asked to assist. Vasquez & Javier (1991) have previously noted the positive impact of willing interpreters.

The clinician noted that although the trained interpreters were willing, they did not show the same feelings of pride and enjoyment as the untrained interpreters. It is questioned whether there would be more genuine excitement on the part of the trained interpreters if they were acknowledged and received appropriate remuneration for the essential services that they render.

viii) The Role of the Interpreter within an Institution

As mentioned in Section One, there is some debate as to the neutrality of the interpreter in clinical encounters. Interpreters may be asked to communicate information or promote values which are not their own, but those of the hospital administrator, institution or professional (Kaufert & Koolage, 1984).

Some researchers believe that the neutrality or invisibility of the interpreter has an ideological function which may mask relations between those in the encounter (Drennan, Levett & Swartz, 1991), while others believe that the recent move to make translation visible is a political one (Venuti, 1992 in Muller, 1994). Kaufert & Putsch (1997) state that policies that restrict the role of the interpreter and emphasise neutrality and invisibility may ignore other dimensions of the interpreter's activities in health care. In line with this, proponents of the advocacy model of interpreting advocate that autonomy from the service provider structures is crucial for interpreters, in order that they are free from the constraints of employee status (Shackman, 1985; Sanders, 1991 in Drennan, 1998).

In this study, the trained interpreters did not have autonomy since they were working for larger organisations, the staff of which were their superiors. This could have potentially resulted in conflict in instances where the interpreters needed to act as patient advocates, but also felt loyalty to the establishment in which they were working. Surprisingly such role conflict in the context of this study did not appear to occur. This was thought to be because the institutional context of the centre and community-based project within which the study was conducted, differed to institutions documented in other fields and studies, by virtue of its smaller size, and the very personal, patient-centred management of the project. Within this context the interpreters were able to vacillate between the roles of cultural broker, patient advocate as well as a valued member of a multi-disciplinary team. In contrast, the untrained interpreters felt greater loyalty to the patients, and had no allegiance to the institution, whom they appeared to not even consider, from the examination of the post-interview discussions. However, all of the untrained interpreters were mothers of hard of hearing or deaf children, and this was thought to result in their firm support for the caregivers. Swartz (1998) suggests that if 'ad hoc' interpreting practices prevail within an institution, this could impact tremendously on the interpreting relationship. For example, cleaners, nurses and relatives will all have differing institutional interpretations, which will

University of Cape Town

affect how the interpreter works (Swartz, 1998). This implies that 'ad hoc' interpreting practices further complicate the position of the interpreter in health care. This further highlights the need for institutions providing health care services to have a policy working to address the needs of all its clients, thereby ensuring equal access to health care services.

3.5 TRAINING

From this research, the need for trained interpreters has become clear. However, it became apparent from post-interview discussions with the interpreters that exposure to the field of Speech-Language and Hearing Therapy, appeared to greatly assist the trained interpreters in increasing accuracy and facilitating understanding of the caregivers within the interpreted interviews. It is of importance to note that the trained interpreters had not received specialised training in interpreting for rehabilitation sessions, but all three trained interpreters were familiar with many of the terms and concepts used due to having had some experience interpreting in the field. In addition, the clinician acknowledged the importance of training medical professionals to work more effectively with interpreters. Thus, a number of aspects that emerged within the theme of training were discussed, including the need for field-specific training, content and skills acquired during training, and most importantly training of professionals.

University of Cape Town

3.5.1 Need for Field-specific Training

The need for interpreters with field-specific knowledge in medicine, as well as other disciplines has been verified by the observations and comments of several researchers (Marcos, 1979; Kline et al., 1980; Wood, 1993; Drennan, 1996a, 1998).

The clinician in this research acknowledged the importance of field-specific knowledge, particularly in the field of Speech-Language and Hearing Therapy. She felt that having field-specific knowledge would definitely reduce the number of inaccuracies, particularly those related to medical terminology and difficult concepts related to the field of Speech-Language and Hearing Therapy.

Cl: *"...so if she had a more detailed understanding of our field, the language we use and the sort of questions we ask and why we ask them, and the dynamics of an interview through a translator, I think it would have made a big difference."*

Furthermore, the clinician felt that because parents are often finding out for the first time that their child is hard of hearing or deaf, and thus have to deal with issues related to acceptance of the deafness and rehabilitation options in a short space of time, the interviews are often emotionally charged. The need for general counselling skills was well acknowledged, but in addition, the often emotive nature of the rehabilitation sessions indicated the need for training in specialised counselling skills, particularly honed for the field of Speech-Language and Hearing Therapy.

The trained interpreters, although they had not all had field-specific training per se, all had exposure to the field of speech-language and hearing therapy. They felt that having experience in the field prepared them for the demands of the interview to a better extent than had they not gained this experience.

TI: *"...for me it's knowledge, because firstly before I worked here, I didn't know about children who are not hearing properly, how to handle them, but now for me it's really a big privilege to do this work..."*

The clinician also felt that having this field-specific knowledge would put the trained interpreter on a more even par with her and level out the power imbalance between her and the interpreter. She felt that the trained interpreters that she had worked with in this research were more competent, in part due to their exposure to the field of Speech-Language and Hearing Therapy, and not having this experience was a large disadvantage to the untrained interpreters in that it reduced their competency. However it cannot be assumed that experience in itself is enough for an interpreter to acquire sufficient field-specific knowledge to prevent misunderstanding and misdiagnosis. Thus, training in the field is considered necessary for providing effective interpreting services.

University of Cape Town

3.5.2 Content and Skills Acquired During Training

As mentioned previously, all three trained interpreters were trained within a formal training programme offered by a locally based organisation. The vision of this organisation is to improve effective communication through the training of interpreters, develop materials that are linguistically and culturally empowering and provide ongoing support and training to interpreters (Daki, 2001). The programme was started to address communication needs which were identified by research conducted in health care facilities in the Cape Peninsula between 1993 and 1994 (Daki, 2001).

As indicated previously in Section 2.3.2.4, the theoretical modules were comprised of interpreting, counselling and cultural issues, skills development, health information including health promotion, ethical issues, administration and constitutional affairs (Ntshona, 1999).

The trained interpreters all felt that their training had adequately prepared them for working within health care, particularly for the linguistic and cultural diversity present within the health care setting in the Western Cape. They all mentioned to some extent how complex the act of interpreting is and how they feel that training in interpreting and health care policy is essential. They felt that their training had equipped them with enough "knowledge and understanding of hospital policy" to assist the clinician or doctor in getting the information she/he needs, in the right way, but still remaining loyal to the patient and the institution wherein they work. Two of the trained interpreters work at a paediatric hospital and one works at a paediatric speech and hearing therapy community and centre-based programme. Both these institutions have a policy working to address the needs of their Xhosa-speaking clients, which ensures equal access to care for these clients. They also have a job description, which they feel gives them power to set boundaries on what is expected of them, and thus allows them to feel empowered in their jobs. The researcher acknowledges the importance of job descriptions for employees, particularly interpreters, considering the haphazard use of interpreters and their often unrecognised status.

Because of the paucity of trained interpreters in the Western Cape, and the resultant 'ad hoc' status of interpreting services, health care professionals often assume that because

University of Cape Town

nurses, cleaners and others working within the health setting can speak the patient's language, they are also able to understand and sympathetically portray the cultural background of the client (Swartz, 1998). One of the trained interpreters in this study indicated that even though she comes from a similar cultural background as her clients, they often share differing beliefs and attitudes. She felt that her training helped her to depersonalise culture, and focus on the patient's beliefs, instead of her own opinions and attitudes.

The only query that one of the trained interpreters had was whether she should speak to the mother in the first or second person. She was unsure whether she should make as if she was asking the question, which she felt could be misconstrued, or whether she should begin every sentence with "she says", which she felt was cumbersome. The researcher believes that this is a matter of personal preference of the parties involved in the interpreted interview, and perhaps this is an issue that needs to be discussed in the recommended pre-interview discussions between the clinician and the interpreter.

One aspect of the training that all the interpreters found useful was role-playing and sketches, since they were seen as a means of evaluating and developing their skills, gaining a better understanding of the complexities of the interpreted interview, and learning from each other. They felt that these role-play situations showed them the importance of being tolerant with patients and doctors and of brokering the cultural differences between the two groups involved in the interpreted interview.

University of Cape Town

TI3: *"...you know those short sketches, they gave you more knowledge and understanding...that a doctor will come and a parent comes all the way from the Transkei. She knows nothing about this language* [English] *and she will talk her way of living... and explain what's wrong using all those actions, while you must wait and listen to what she's saying and try to understand, while the doctor is rushing...but you have to be patient..."*

According to the trained interpreters, the most important skills that they acquired in their formal course were:

- Professionalism
- Efficiency
- Assertiveness
- Recognition of need for respect of clinician and caregiver
- Asserting authority
- Counselling skills
- Cultural appropriateness
- Recognition of need for confidentiality and discretion

Indeed in many of these aspects, there was a distinct difference between trained and untrained interpreters. Except for efficiency and inconsistent assertiveness displayed by some of the untrained interpreters, the above-mentioned skills were not frequently exhibited by the untrained interpreters.

All of the untrained interpreters expressed an interest in receiving training and acquiring the skills needed to be a good interpreter. They realised some of their weaknesses and acknowledged the need for training of interpreters.

3.5.3 Training of Health Care Professionals

Findings from this study support the increased awareness that for health care professionals to work effectively with interpreters, they need to know the kinds of problems interpreters have, as well as what to expect from them (Diaz-Duque, 1982; Vasquez & Javier, 1991; Crawford, 1994; Drennan, 1998). Furthermore, the interpreting situation can be further complicated by clinicians who are not cognisant of the inherent complexities of the interpreted consultation.

The clinician in this study realised the necessity of training and expressed an interest in receiving additional training in the effective use of interpreters. In addition, she felt that although she was relatively experienced using interpreters, the majority of her experience was with trained interpreters, who she was familiar with, and whom had some experience

University of Cape Town

interpreting within the field of Speech-Language and Hearing Therapy. Considering this, she indicated that when she worked elsewhere, she might not always be able to be as dependent on a particular interpreter whom she trusts and she would have no idea of the interpreter's competency or experience. This would require her to compensate for any possible lack of competency by using a number of strategies, such as those mentioned in Section 3.1.1.5, to facilitate effective communication between herself and the patient. The clinician acknowledged that using long sentences and speaking at a rapid rate, in the third person and in more impersonal modes (e.g. tell the patient that..."), could make an accurate interpretation more difficult. This implies that training of the clinician in the above-mentioned strategies, would result in a more accurate interpreted consultation.

The trained interpreters in this study also expressed the importance of doctors receiving training in how to work with them more effectively. They felt that often doctors were rushing them or impatient with them when they were trying to facilitate cultural brokerage or increased understanding of the patient. Hence, if they had a greater understanding of the role of the interpreter and the enormity of the existing cultural barriers to effective communication, they might be more accepting and understanding of their need to spend time explaining certain aspects to patients. In agreement, Crawford (1994) reported that doctors are not trained to use interpreters in a sensitive and productive way. There appears to be a widespread assumption amongst doctors that to be bilingual to whatever variable degree, equips a person to interpret, without further inquiry into aptitude, attitude, level of exposure of the field, or training of any nature (Crawford, 1994). The findings from this study, indicate that there is a definite need for clinicians to be trained in interpreting practices, considering the complex nature of the interpreted interview.

University of Cape Town

3.5.4 Guidelines for the Training of Interpreters and Clinicians Working with Interpreters

Proposed guidelines for the training of interpreters and the training of clinicians working with interpreters are presented in Table 3.4 and 3.5. These guidelines were developed by the researcher based on the numerous findings that emerged from this study. The guidelines are felt to be applicable across all disciplines in the health sector.

Table 3.4: Guidelines for the Training of Interpreters

	GUIDELINES FOR THE TRAINING OF INTERPRETERS
Pre-Training:	□ Screening for language competency in both languages □ Interviews to assess the potential of applicant, education, experience in health services, etc.
Training: *Theory*	a) Professional Practice □ Roles and duties of an interpreter within a patient-centred approach (i.e. interpreting, advocacy, cultural mediation, counselling, etc.) □ Constitutional Affairs □ Skills development (assertiveness, mediation, negotiation, advocacy, problem solving) □ Counselling course □ Impact of culture on communication and cultural differences between participants □ Health information and health promotion □ Discussion of code of ethics or good practice, need for confidentiality, etc. b) Linguistic & Paralinguistic Skills □ Enhancement of both languages □ Discussion of types, contribution and causes of mistranslations to heighten awareness □ Strategies to facilitate accurate transfer of information • Use of clarification strategies to check clinician and caregiver have understood • Use of rephrasing or repetition when statement was not understood by clinician or caregiver • Moderate rate of speech • Use of culturally appropriate analogies or examples • Importance of pre- and post-interview discussions between interpreter and clinician □ Strategies to facilitate appropriate interaction • Observation of non-verbal behaviours and body language of clinician and caregiver • Appropriate seating arrangements • Awareness of culturally appropriate behaviours • Appropriate display of empathy from interpreter and conveyance of empathy from clinician • Importance of interpreting emotive components of communication, and non-verbal aspects of communication • Importance of pre- and post-interview discussions between interpreter and clinician □ Course on translation (of written documents, etc)
Practical	□ Role play □ Group discussions □ Practice of the above-mentioned strategies
Post-Training:	□ Official credentialing & certification □ Continuing education on interpreting practices, updates on new developments, etc., for maintenance and expansion of knowledge □ Course in specific knowledge necessary to work competently in selected field.

Note: Red writing indicates suggestions that were in agreement with those from an existing formal training programme (Ntshona, 1999).

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Table 3.5: Guidelines for the Training of Clinicians Working with Interpreters

	GUIDELINES FOR THE TRAINING OF CLINICIANS WORKING WITH INTERPRETERS
Training: *Theory*	a) Professional Practice □ Heighten awareness of multiple roles and duties of an interpreter (i.e. interpreting, advocacy, cultural mediation, counselling, etc.) □ Health care services: current state of health care and interpreting services, population groups served, etc. □ Models of service delivery: discussion of the bio-medical vs. bio-psycho-social approach □ Impact of culture on communication and cultural differences between participants of the interpreted interview • NB: training in how to conduct a cultural narrative • Education about traditional medicines and practices □ Discussion of research findings on effective interpreting practices
	b) Linguistic & Paralinguistic Skills □ Increasing working knowledge of Xhosa: short course on basic greetings, familiarisation with field-specific terminology (e.g. 'ear', 'hearing aid', 'speech and language', etc.) □ Discussion of types, contribution and causes of mistranslations to heighten awareness □ Strategies to facilitate accurate transfer of information • Use of trained interpreters, as opposed to untrained or lay interpreters (e.g. family members, or hospital personnel not qualified to interpret) • Use of clarification strategies to check caregiver and interpreter have understood • Control length of utterances • Speak in the first person • Break up complex concepts of lengthy explanations • Use of rephrasing or repetition when statement was not understood by interpreter • Moderate rate of speech • Avoidance of use of medical jargon, idiomatic expressions, etc. • Use of examples or analogies • Use of pictures or models to illustrate difficult concepts (e.g. anatomy of the ear) • Use simple form of verbs (i.e. active rather than passive) • Importance of pre- and post-interview discussions between clinician and interpreter □ Strategies to facilitate appropriate interaction • Always greet the patient in their own language to establish initial direct contact • Observation of non-verbal behaviours and body language of interpreter and caregiver • Appropriate seating arrangements • Awareness of culturally appropriate behaviours • Importance of pre- and post-interview discussions between clinician and interpreter
Practical	□ Role play □ Practice of the above-mentioned strategies
Post-Training:	□ Official certification □ Continuing education on interpreting practices, updates on new developments, and reinforcement courses

University of Cape Town

3.6 SATISFACTION

Assessment of satisfaction does not appear to be a reliable measure of efficacy of the interpreted interview, since all of the caregivers as well as the trained and untrained interpreters, were always satisfied with the interpreted interviews. The clinician appeared to be the most reliable barometer of the success of the interview with regards to accuracy, since the objective findings from the revised MAT largely corroborated her subjective opinions. She was primarily unsatisfied with an interview in the following situations:

- When she felt accuracy was negatively affected
- When she was confused at times during the interview about what the caregiver had said
- When she felt the interpreter was taking over her role and asking questions she had not asked
- When she felt excluded from the interview, when the interpreter and the caregiver were having a lengthy discussion and she could not understand what they were discussing or what question the discussion was related to.

These factors were described by the clinician as being present primarily with the untrained interpreters, although they did occur with the trained interpreters at a reduced frequency.

In addition, the clinician showed variation in her reports of satisfaction when it related to transaction versus interaction. She tended to be more satisfied with the trained interpreters' transaction of information, and contrastly with the untrained interpreters interaction with the caregivers. Thus the understanding of the trained interpreters as well as the accuracy of the information they conveyed, was definitely felt to be better with the trained interpreters. The clinician's perceptions of the accuracy of the trained interpreters was consistently supported by their performance on the revised MAT. She did however realise that the accuracy of the interpreted interview alone, did not determine its success. The interpersonal interaction of the interpreters, their display of affection and empathy, as well as the use of non-verbals also impacted on the interpreted interviews to a large extent, as discussed in Section 3.2. The clinician felt that the often informal and highly supportive nature of the interaction between the untrained interpreters and the caregivers, as well as their genuine display of empathy was more conducive to successful interaction.

University of Cape Town

As mentioned previously, both trained and untrained interpreters were generally satisfied with the interpreted interviews. However, closer examination revealed that the trained interpreters were more satisfied with how they had conducted themselves during the interpreted interview and their degree of accuracy, while the untrained interpreters were more satisfied with the enjoyment they felt being an interpreter as opposed to their performance during the interpreted interviews.

It is logical that the untrained interpreters, in particular, may be reluctant to admit to dissatisfaction, in that it may draw attention to their inadequacies. The caregivers, on the other hand, might be reserved in the expression of their real opinions of the satisfaction of the interview, since they were content at being heard or having someone assist them, to a lesser or greater degree. This is in accordance with Crawford (1999), who reported that patients were resigned to long waits in cues, and their expectations of treatment were low. If they were fortunate to have an interpreter, trained or untrained, they had no complaints or thoughts about the quality of the interpreting. They were only too happy with even a minimal level of understanding, and more particularly for the presence of another Xhosa-speaking person in their medical encounter with potentially some sort of authority.

The varying opinions of satisfaction or dissatisfaction expressed by participants of the interpreted interview, reveals that satisfaction is a subjective assessment of performance, and thus, is perhaps not the most reliable measure of efficacy of the interpreted interview.

University of Cape Town

structural inequalities and societal conflicts continue to influence the shape of a medical encounter (Lazarus, 1988; Pappas, 1990).

Furthermore, research has indicated that doctors have become accustomed to getting by with sub-standard communication, where frequently only rudimentary and inadequate medical histories are obtained, on which diagnosis and treatment plans are made. This has been referred to as 'veterinary care' and implies acceptance of a sub-standard level of communication with patients who speak indigenous languages (Kleinman, 1977 in Drennan, 1998). Accordingly, it has been noted that health care has become increasingly bureaucratised, where "administrative functions are prioritised, creating notions of minimum standards of care, reductive understandings of access to services, rather than access to care" (Swartz & Drennan, 2000, p. 189).

If the health system is to become more accessible, legitimate and effective, the political will to address these communication barriers will have to be found. Lack of time and resources is often cited as the reason for inadequate health care, however, as Crawford (1999) suggests, this shows extreme shortsightedness on the side of health professionals. It is clearly a multi-faceted problem that has to be conceptualised in a more global way than merely the provision of interpreters, although this is clearly indicated. A number of central themes that emerged in this research, in connection with other researchers' suggestions will be systematically discussed as possible suggestions to improve health care services to linguistically marginalised communities.

University of Cape Town

4.1.1 Need for Black Clinicians and for Clinicians to Learn an Indigenous Language

A number of solutions for dealing with language diversity in health care settings have been proposed. Two suggested solutions are that clinicians should learn the indigenous language of their service users (e.g. Xhosa) and the training of more first language Xhosa-speakers as clinicians to enable direct interaction with their patients.

Numerous researchers have highlighted that health care providers, in an effort to provide delivery of an effective service, should be encouraged to learn the language spoken by their patients (Baker, Hussain & Saunders, 1991; Ntshona, 1997; Swart, Drennan &

Crawford, 1997; Drennan, 1998; Swartz, 1998). In fact, it has been suggested that all health care providers, and indeed all human service personnel, should have training in one or other indigenous language (Swartz, 1998).

In line with these suggestions, health care professionals acknowledge that they need to learn the indigenous language of their region in order to serve their patients adequately, but few have been able to make any progress in this direction (Crawford, 1999). This is possibly due to the fact that language acquisition as an adult is not easy. Sustained high levels of motivation are required, often for years, to reach adequate proficiency and even then insufficient levels of language and cultural knowledge might have been acquired by the health care professional, preventing the interaction with the patient from being satisfactory (Wood, 1993). Swartz & Drennan (2000) state that doctors' complaints that learning Xhosa is difficult for an English-speaker are justified. However, it should also be noted that although English-speakers have a reputation worldwide for resisting multilingualism, English-speakers are capable of learning other 'difficult' languages if they have to do so (Swartz & Drennan, 2000). Nonetheless, they make an interesting point in querying whether it is worth risking learning a language only to verify what South African socialism has made us feel - that irrespective of what White clinicians do, they might never understand Black people (Swartz & Drennan, 2000).

Very recently, much transformation has occurred throughout tertiary education. Currently, medical students at a local training institution are required to take a one-year course of Xhosa instruction. However, this has proven to be ineffective in teaching students to express themselves to Xhosa-speakers or indeed to understand much beyond a crude first level of inquiry from their patients. A new Xhosa course is in the process of being implemented, where a full Xhosa course (four years) will be integrated into the medical curriculum. However, due to the multilingual nature of South Africa, there is concern that qualified clinicians will be exposed to different indigenous languages than the one they might have acquired in their training programme. This is of particular concern in the Gauteng region, where languages are even more widely dispersed than in Kwazulu Natal and the Western Cape. Thus, serious consideration needs to be given to this dilemma before embarking on a new programme, such as the proposed four-year course in an indigenous language.

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Furthermore, the researcher poses the question of whether first language English or Afrikaans-speaking clinicians can acquire sufficient levels of language proficiency and cultural knowledge in an indigenous language, in order to be able to offer high levels of health care services to speakers of that language. It is proposed that clinicians who are second language speakers of Xhosa may never acquire sufficient proficiency in Xhosa to be able to communicate effectively with their patients without the use of an interpreter. In addition, although language and culture have been proven to be inextricably intertwined, learning an indigenous language such as Xhosa does not bring with it a simultaneous understanding of the Xhosa culture. Therefore, spending years learning a language that one is unlikely to be completely proficient in, when that might not necessarily enhance the interpersonal interaction between clinicians and patients in health care services, needs serious consideration. It is felt that this point warrants more in-depth discussion and research consideration.

In contrast to the above-mentioned proposal, clinicians with some knowledge of Xhosa have previously reported that because they could understand Xhosa, they were aware of the grave extent of misapprehension, mistranslation, loss of meaning and consequential misunderstanding that occurred on a daily basis between doctors, nurses and patients (Crawford, 1999). Furthermore, they stated that when patients realised that they could speak and understand some Xhosa, the patients turned to them with such hope, that the clinicians began to understand how badly they are being treated in health care settings. However, it is proposed that this view is one-sided and perhaps exclusionary, since this reflects the clinicians' beliefs, and not the patient's perceptions of the impact of doctors speaking their language. In addition, it is questionable that a limited vocabulary and understanding of Xhosa, would provide such comfort with the use of the language to the extent that errors and misunderstandings would be picked up in an accurate and continual manner. Johnson et al. (1999) reported that clinicians in their study who were able to speak a few words in the patient's language, enabled them to establish rapport with the patient, as well as a sense of being able to communicate with their patients in their language, despite it being to a small degree. It is believed that Johnson et al.'s (1999) findings are more in line with the benefits of being familiar with an indigenous language, that of building a rapport relationship with a patient, as well as showing a willingness to learn and a respect of their language and culture, although it might never be possible to be proficient enough to communicate with them, without the use of a trained interpreter.

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Furthermore, a limited knowledge of Xhosa might in fact be hazardous considering that clinicians might assume that they have understood certain aspects relating to the patients illness or complaints, when they actually might not have understood the more subtle nuances of the information or may have associated a different meaning to the patient's words. This is particularly important in health care services where the onus is placed on the clinician to retrieve the necessary diagnostic information from the patient and there is often a need for in-depth counselling.

In addition, it has been proposed that doctors learning the language of their patients is not enough to redress the issue of cross-cultural communication (Erzinger, 1991). In conjunction with the articulation of understandable questions, the doctor's conversational manner should reflect an ability to listen, understand and encourage the patient's responses in their first language (Erzinger, 1991). These skills are thought to be very difficult to do simultaneously when one is acquiring a second language. Therefore, Erzinger (1991) suggests that doctors allow patients to assist them with their language difficulties. The patient's efforts to teach misunderstood terms should be seen as assisting to transcend difficulties of communication and thus their efforts should be respectfully acknowledged and appreciated as such. This implies that an understanding of these aspects should be included in training programmes for clinicians, to allow ease of communication to be reciprocal and more efficient.

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Consequently, the researcher proposes that the focus of training programmes for health care professionals should be on facilitating training in *linguistic and cultural sensitivity*, as opposed to the acquisition of an indigenous language. More importantly, the learning of an indigenous language by clinicians, should not in any way obviate the need for trained interpreters, since they would still be necessary to bridge cultural and linguistic divides between patients and clinicians and enhance communication to the extent that both sides are well understood.

An additional measure for meeting the needs of the linguistically and culturally diverse South African population, is the employment of clinicians who speak indigenous languages and who can thus communicate directly with their patients. As Swartz (1998) suggests, this would surely solve the problem of unequal language access in health care. It is proposed that bilingual health care workers or clinicians, whose primary role is direct

care or support to providers, would be better equipped than interpreters, since their use of language skills and cultural knowledge would be more extensive than the interpretation of information seen in formal interpreters. Although this seems logical, the reality of the problem in health care at present is that the majority of the personnel are not first language speakers of the indigenous languages, and have not acquired any of the indigenous languages as second or third languages. Swartz (1998) proposes that this is due to a number of factors, the most significant being limited access to higher education for members of all language groups. This is compounded by the fact that proficiency in indigenous languages was often not valued or necessary as part of the competency of a clinician.

In line with the Minister of Education, Kader Asmal's recent call for educational institutions to show commitment to and implement transformation agendas, a response has been noted nation wide and training students representative of the population demographics is indeed being attempted. As Ncayiyana (1999) has indicated, one of the greatest challenges faced by all medical schools today, is to find academically qualified Black students for admission to the medical curriculum. Similarly, within the profession of Speech-Language and Hearing Therapy at present, ever-increasing attempts are being made to train a representative sample of students. Thus, although these aspects are changing as the country continues it's political and albeit lagging economic transformation, it is anticipated that the training and employment of clinicians who are first language Xhosa-speakers, or even the teaching of indigenous languages with any level of proficiency, will not be a speedy process. More appropriately and in line with the Minister of Education's estimations, this will be a time-consuming procedure which might be slow in gaining momentum and thus the impact will not be immediate (Asmal, 2000, in Klein, London & Perez, 2001). Therefore, it is proposed that until such a time as this representative sample of clinicians is met, the immediate need for full-time, trained interpreters in health care will have to be addressed. Furthermore, considering the multilingual, multicultural populace in this country, as well as the fact that there will always be a proportion of first language English and Afrikaans-speaking clinicians in this country, it is likely that the need for interpreters will be continuous and persistent in the future.

University of Cape Town

4.1.2 Need for Policy Formation

Clearly, even when there is a well-described need, many facilities fail to deal with language and cultural problems in a formal operational sense (Putsch, 1985). Johnson et al. (1999) state that the difficulties in matching the language skill available with the patient need, confirms the need for service models, management processes and policies that would facilitate more effective use of language skills and cultural knowledge in the clinical setting. In addition, they state that there is a paucity in the knowledge base required to provide guidelines for effective service provision. Thus, the need for policy formation is clear.

Although to date South Africa has eleven official languages, prior to the inception of democracy in 1994, English and Afrikaans were the only 2 official languages. This decision to have eleven official languages represented an official recognition, during the country's transition to democracy, of the political necessity to redress power imbalances which existed previously along racial and language lines (Swartz et al., 1997). Swartz (1998) reminds us that an aggressive language policy can radically change the accessibility of language services, but also how policies in the past have helped keep services largely unavailable to members of other language groups. The proclaimation of eleven official languages represents an enormous challenge for policy makers in South Africa, but it also arouses a sense of hope that access to services, based on race and language issues, need not be unequal (Swartz, 1998). However, the reality of the situation demonstrates that inequality across languages is still evident.

University of Cape Town

It was believed that post-apartheid South Africa would bring with it a period of growth for indigenous languages, as well as a commitment from government to supporting and sustaining this process (Drennan, 1998). Instead, as Du Plessis (1999) suggests, what has actually occurred is that English has become the language of the new political dispensation and the supposed shift in power has led to the advancement of English, as opposed to the indigenous languages.

Complicating language policy formation is the fact that language policy in health is not only service driven in terms of what users require to access services. In addition, there are ideological and political struggles expressed through language (Swartz et al., 1997). In a

system previously riddled with racism, making language services available in an 'ad hoc' fashion is not sufficient. Although it might grant a certain amount of improved access, it would by no means alter the dominant structures and discourses in health care that exclude and marginalise both patients and clinicians. As a result, patients and staff who have not spoken the dominant languages of English and Afrikaans have been excluded from the mainstream. Any attempt to redress the situation must take the voices of these excluded groups into account (Swartz et al., 1997).

Upon examination of existing language policies in South Africa, it is clear that there is lack of clarity regarding policy issues around language. The application of a new language policy without the development of a clear implementation strategy by the government, does not reflect an adequate understanding of the importance of a multilingual society, where people are not marginalised by the dominance of any particular language (Heugh, 1995). Reagan (1995) claims that the extent to which current language policy in South Africa aims for equal status across all languages, is not clear. Heugh (1995) indicates that there has been a discernable shift in statement of policy from linguistic integration, a system of drawing together disparate groups to co-exist interdependently to multiculturalism, a system that recognises diversity and issues of power relationships across all languages. Despite this, Beukes (1996) has noted that there is a considerable trend towards unilingual practice in public services in that the government has failed to acknowledge the role of language in access to services and was not taking any steps to remove language barriers to such access. Furthermore, she argues this is due to a variety of factors, including the fact that the role of language in development has not yet been properly deliberated, as well as the assumption that multilingualism leads to increased government expenditure. She concludes that a language policy strategy for public service must be adopted in order to achieve functional multilingualism (Beukes, 1996). It has been proposed that passivity with regards to language inequality coincides with a neglect of racial inequality (Drennan, 1998). It is ironic that one of the primary aims of the new political dispensation was to eradicate racism, and yet the existing language inequality within health care services appears to be partially reproducing racist attitudes.

Reagan (1995) states that as long as language planning and language policy formation is seen as a top-down activity, removed from those whose lives it affects the most closely,

University of Cape Town

and is perceived as an activity only for those with specialised expertise, it will most probably continue to be generally ineffective. He suggests that language policies should be devised in consultation with, and with the support and involvement of those they are intended to serve. This in turn requires that "ethnic, cultural and linguistic rights, whether conceived in individual or group terms, will of necessity have to be protected, as will the political, social, educational and economic rights of all South Africans" (Reagan, 1995, p. 327). As suggested by Fortier (1997 in Erasmus, 1999), the success of the transformation process is dependent on "a committed partnership of government, communities, providers and interpreters" (Fortier, 1997, p. 177 in Erasmus, 1999). Thus all those who have an interest in, or are aware of the need for effective, linguistically equitable service provision in health care, have a role to play.

In support of these findings, the metatheoretical framework of Participatory Action Research (PAR) was thought to be the ideal type of research to undertake in this field, and thus has been adopted by Erasmus and her colleagues at the Unit for Language Facilitation and Empowerment (Erasmus, 2001). The PAR approach has been adopted because the status quo has existed for so long, and the problems regarding interpreting in health care are of such large scope and magnitude, that it's going to require a structured, and powerful approach to change the existing system. PAR claims there must be co-ownership in the research problem and results must be shared with all people involved in the project (Babbie & Mouton, 2001). The key elements of the PAR approach include the generation of knowledge for the purposes of action, with the researcher as an agent of change, and the incorporation of local knowledge and thus participation from others involved in the project. The PAR approach also emphasises the need for democratic research, as well as respect for the interests and culture of the participants (Babbie & Mouton, 2001).

University of Cape Town

In line with the PAR approach, the provincial Department of Health should be encouraged to become involved in the transformation of this aspect of health services in the province (Erasmus, 2001). The need for legislation is compulsory so that language rights are respected and recognised. Because there is no clear legislation, institutions get away without interpreters and offering sub-standard service provision. There is a concurrent need to sensitize users of interpreters, thus for training of professionals working with interpreters. At the same time, there is a need to train interpreters to become trainers themselves, which would result in a much needed cascade effect. Resistance to change

due to ignorance of stakeholders is evident and thus there is a general need to heighten awareness. This is clearly going to be a long-term process which is dependent on the adoption of a holistic approach, such as participatory action research.

Furthermore, it has been suggested that research findings be effectively utilised so that the situation is improved from the results of the research (Erasmus, 2001). Often there is no report back to the people from whom the research was obtained, which excludes them from actively participating or contributing to change that will in turn enhance their lives. The use of a participatory approach to research, which includes participants from differing levels of power and influence, includes reporting back to participants to allow for the success of the project (Erasmus, 2001).

Mulenga (1994, in Collins, 1998) neatly summarises why the participatory research approach is so applicable to the South African population: *"Participatory research refers to an emancipatory approach to knowledge production and utilisation. Its main aim is to actively involve the oppressed and disenfranchised people in the collective investigation of reality in order to transform their reality"* (Mulenga, 1994 in Collins, 1998). Thus, it is proposed that this approach is ideal in the South African context to involve the previously disempowered population, and allow them to be active participants in the transformation of health services in South Africa.

University of Cape Town

Although the provision of trained, paid interpreters is clearly indicated as part of a strategy to transform health care services, there are major obstacles to doing this. As mentioned previously, health services throughout the country are in a situation of serious financial strain. Interpreting services within health care in South Africa, have no coherent or joint organisation and this as well as the financial constraints, make it very difficult to convince authorities to open posts for interpreters at institutions (Erasmus, 2001). As Swartz et al. (1997) suggest, in the context of diminished funding for public sector services, it is unreasonable to expect that there will be sufficient funding to provide interpreters on a large scale in South Africa in the near future. In addition, the belief of many multilingual South Africans that clinicians should be multilingual, will militate against funds being channeled into interpreter programs. Furthermore, if such funds are to be diverted into interpreter programs, there needs to be research to indicate that such programmes are financially worthwhile, in that they save costs in some way.

Although it is appreciated that the health sector is experiencing severe financial constraints, we can no longer hide behind this issue as a means of sidelining the importance of linguistically equitable service provision in health care. Funding needs to be made available for the crucial need for interpreter services in health care. Furthermore, even if transformation is successful in training clinicians representative of the linguistic and cultural communities in South Africa, it is quite likely that interpreting services will permanently be needed in this multilingual, multicultural 'rainbow' nation.

It is proposed that there are a number of strategies that could be employed at local and national levels, to hasten linguistically equitable delivery of health care. As Drennan (1998) suggests, the Health Professions Council of South Africa should be lobbied to specifically address the ethics and risks of the professional activities of their members without interpreter assistance. If professional guidelines stipulated that certain practices are unethical, and therefore liable to prosecution, there would be immediate impetus for institutions to make use of appropriate services for linguistically marginalised patients. There is a concurrent need to heighten the awareness of health care professionals working with speakers of indigenous language, that linguistically equitable service provision is a right and not a privilege. In addition, findings from research studies such as this, could be used to lobby provincial health departments regarding interpreter services. Despite shrinking budgets, there appears to be a commitment to expand services in primary health care, and if the importance of interpreting at this level of service provision were to be recognised, other systematic changes might follow (Drennan, 1998).

Erasmus (1999) suggests that a comprehensive plan of action be implemented to cultivate a greater awareness of the need for interpreters within health care and in the communities. Empowerment through effective communication is indispensable to the rendering of a good service (Corsellis, 1999a). Clearly there is a need for policy regarding language equality in health care to be implemented, which could start with the provision of full-time, trained interpreters in health care services. There is a concurrent need for professionalisation and accreditation of trained interpreters to elevate their status and enable them to be accepted as part of a multidisciplinary team.

University of Cape Town

4.1.3 Need for Training and Professionalisation of Interpreters

Concurrent with the shift towards greater recognition for the need of interpreters in health care, is the need for a better understood and more well defined role and function of the interpreter. Several studies have highlighted the frequent expression of dissatisfaction of interpreters at their lack of credentials and resultant unacknowledged status (Crawford, 1994; Muller, 1994; Drennan, 1998). In addition to this, their part-time employment as well as poor remuneration is thought to exacerbate their feelings of inadequacy and disempowerment. Erasmus (2001) suggests that these feelings could be diminished or alleviated by professionalising interpreters, which will be discussed shortly.

Currently, there is no accepted status and place for interpreters in the medical hierarchy and there are no posts or funding for interpreters at government level. In addition, there is no agreement as to what the role and duties of interpreters should be, as well as with whom their allegiance should lie - the patient or the institution that supposedly employs them? Much of the literature on interpreting indicates that interpreter roles include both the functions of cultural brokerage and advocacy (Kaufert & Koolage, 1984; Crawford, 1994; Herselman, 1994; Swartz et al., 1997; Drennan, 1998; Swartz, 1998). Swartz et al. (1997) state that this role is structurally impossible without a change in the status of interpreters. As Drennan suggests (1998), medical interpreting has been slow to crystalise a clear set of professional expectations, as opposed to other more distinct forms of language practice such as legal interpreting. As a result interpreters are invariably subject to the stresses attendant on fulfilling a function for which there is lack a of definition. The numerous roles required by the interpreter have been discussed in-depth in Section 3.4. In short, the interpreter's position is one of considerable power to shape and influence communication between two parties and extends far beyond that of conveying information from one party to another, to that of cultural brokerage, patient advocacy, and being a member of a health care team. Acknowledging the power that interpreters possess, legitimates the potential in the work of interpreters for redressing the power imbalances in cross-cultural clinical encounters. Furthermore, the expectations that clinicians and patients have of interpreters may be at odds with each other and as such, both parties may place pressure on the interpreter to conform to their agendas (Drennan, 1998). It is proposed that professionalisation of interpreters as well the development of a standard

University of Cape Town

code of practice, which should be available to professionals working with interpreters, would alleviate issues such as the above.

The adoption of an advocacy role by the interpreter has great appeal in South Africa considering the legacy of exclusion and disadvantage, in that it promises an immediate avenue of intervention in institutional contexts (Drennan, 1998). However, the ability required to take on this role within medical interpreting, involves a great deal of skill and expertise. This implies that untrained interpreters attempting to function in this way without the necessary knowledge and expertise, could do more harm than good. In addition, to perform an advocacy role requires a considerable degree of structural and professional support within an institutional context. This would entail heightening the awareness of institutions regarding the critical role of the interpreter. It is proposed structural and professional support would increase considerably if interpreters were acknowledged as professionals, with the very important task of bridging linguistic and cultural divides.

Professionalisation of interpreters refers to appropriate selection, training according to professional standards, accreditation and professional registration of interpreters (De Ridder, 1999). International trends in counties such as Canada, Sweden, Australia, England and Europe, regarding "community-based" interpreting (CBI) show a tendency towards professionalisation, as well as the formal organisation of CBI services. These services are largely still lacking in South Africa (Erasmus, 2001). Although conference and court interpreting services have been established in South Africa, there is no coherent or joint organisation of community-based interpreting. As noted by De Ridder (1999), professionalisation of interpreters would guarantee high-quality interpreting to clients and services, and at the same time ensure status and recognition for interpreters, as well as establishing uniform tariffs.

The importance of transparency in interpreting has recently been emphasised (De Ridder, 1999). This would allow interpreters the freedom to prioritise the creation of meaning in interaction, rather than "striving for depoliticised and decontextualised neutrality" (Drennan, 1998, p. 30). Kaufert & Putsch (1997) suggest that making the role of the interpreter transparent would assist in addressing the anxiety that clinicians have over interpreters having too much latitude in interpreted interviews. In addition, transparency

University of Cape Town

would prevent the principle responsibility of the interpreter, that of mediating communication as accurately and effectively as possible, from being lost in the multitude of conflicting responsibilities of the interpreter. Thus, transparency of the interpreters' role, as well as professionalisation would increase their status within health care, as well as empower them and allowing them to grow in confidence within their profession.

The benefits of using trained interpreters in interpreted consultations was clearly established in this study. An important consideration is that a professional qualification for interpreters cannot be attained without training (Baker et al., 1991). Developing a qualification for interpreters would allow for the establishment of professionals standards and ethics, as well as a means of validating the skills of interpreters, so that they would receive their due recognition in terms of salary and working relationships, and so reduce the reliance of staff on 'ad hoc' interpreting practices (Baker et al., 1991). In addition to training and professionalisation of interpreters, there is also a pressing need for recognition of the skills that interpreters have and thus the provision of appropriate remuneration for these skills.

Without systematic training or credentialling, interpreters' power and legitimacy is primarily limited to situations in which a medical professional requires cultural brokerage. The development of a clear career path for interpreters within health care, with opportunities for systematic training and credentialling may resolve some of the problems associated with role dissonance (Kaufert & Koolage, 1984). Diaz-Duque (1982) strongly urges health care professionals to work with trained interpreters who are familiar with interpreting techniques, patient's rights and the way the health care system functions. He added that there has been general agreement that the use of trained interpreters facilitates understanding between health care provider and patient.

As was seen in the findings from this study, and as previously noted by Erasmus (2001), selection of the appropriate person to train in interpreting skills is crucial. There is currently much debate over who are suitable candidates to train. In this study, linguistic proficiency of interpreters has proven to be an important criteria for success of the interpreted interview, from the perspective of accuracy of the translated material and the satisfaction of the participants. It is thus proposed that screening for linguistic proficiency in the target languages be a prerequisite criteria for training of interpreters worldwide.

University of Cape Town

Accordingly, researchers in the United Kingdom have reported that interpreters are screened for linguistic competence and provided with training for the specialised task of interpreting, before they are used for the very complex task of interpreting (Baker et al., 1991). Furthermore, there were certain innate capabilities or qualities, such as interpersonal skills, that some of the interpreters possessed to a greater degree that made them better equipped as interpreters. Factors such as these cannot be ignored when selecting individuals to be interpreters.

Thus, although it is obvious that interpreters are needed, it is not as obvious who should be doing the interpreting within an interpreted interview, what sort of training is appropriate for the interpreter and how their job is to be structured. Swartz et al. (1997) propose a number of conventional methods of dealing with language diversity in mental health care. Although they have focused on mental health services, these methods could easily be extrapolated to health care services in general, since the same client base is being serviced in terms of linguistic needs.

The *add-on approach* argues that "the best solution for language diversity in practice lies with the employment of interpreters" (Swartz et al., 1997, p.170). This approach was followed by the formal language programme referred to in this study, who trained first language Xhosa-speaking individuals from the community to be interpreters (Daki, 2001). In this case, external funding has allowed for several of these interpreters to be employed on a full-time basis in certain large hospitals in the Western Cape (Ntshona, 1999). The assumption here is that the provincial authorities should take over the employment of these interpreters in due course, since the private funding is not limitless. If this endeavour is in fact achieved, it would be an indication of great progress in language facilitation with regards to health services at a national level (Erasmus, 1999).

In contrast, *the add-in approach* refers to the use of existing personnel as interpreters. Swartz et al. (1997) believe that this practice would be favourable to policy makers, since it would require no additional funding, and because it would institutionalise what has been proven to be an existing practice. However, it is proposed that this approach might not be optimal, unless the existing personnel are trained in interpreting skills. The training of existing staff might prove to be less financially draining than training and employing new interpreters. Erasmus (2001) recommends training lay interpreters who are already

University of Cape Town

involved in interpreting within health care, so that they are familiar with the health care setting, and have realistic expectations of what their duties will be. Thereafter, she suggests entering into negotiation with authorities, offering training courses, career paths and job recognition for these interpreters, thereby allowing them to establish themselves as interpreters (Erasmus, 2001). Once again, the success of this venture would be dependent on the collaboration and partnership of government, communities, health care providers and interpreters.

Having considered the problems inherent in the first two approaches, Swartz et al. (1997) propose a *cultural change model.* Due to the complexity of the issues involved, an eclectic approach is required. They state that "what we need is an analytic approach to understanding both the factors which will enable developments in changes in language practices and those which are unlikely to inhibit such changes" (Swartz et al., 1997, pp. 175). This implies that any investment in changing organisational practices with respect to language, necessitates investment in dealing with the issues involved with such change. They highlight the importance of providing support for clinicians to think through language issues and for re-framing some of the challenges that language diversity poses into manageable portions, and support in a national context for local changes within an enabling framework, rather than a set of inflexible prescriptions.

As is suggested by Erasmus (1999), it is clear that a multifaceted approach such as the *cultural change model,* will have to be undertaken to circumvent the institutional resistance to change in the status quo. It is proposed that public institutions should realise that it is a basic human right to afford clients services in the language of their choice, and infringement of this right is paramount when service providers cannot speak the languages of their clients. Provision should be made for interpreting from and into the official languages within a province. Swartz et al. (1997) propose that the transformation process can be facilitated by changes such as the following: it should be regarded as unethical not to offer interpreting services if a patient cannot communicate without one, the circumstances under which an interpreter is present should be defined, and multilingualism should form part of the training of all health care professionals. Finally, as Erasmus (1999) suggests, the need for people to work together in a united front is emphasised.

University of Cape Town

4.1.4 Need for Training of Clinicians in Interpreting Practices

One of the statements from the Draft Declaration for Health Care Professionals at a medical training institution is: *"I shall strive to improve the well-being of individuals, groups and communities within my care within available resources and sustainable facilities;* ***respect their right to participate in all decisions relating to their treatment and rehabilitation;*** *maintain confidentiality;* ***develop the communication skills necessary to promote health, treat disease, manage disability, alleviate suffering and improve quality of life with due respect for cultural contexts;*** *and promote both the human rights of individuals and ....to achieve improved population health and social cohesion."* (in Klein, London & Perez, 2001). Clearly, this Draft Declaration reflects transformation. However, since learning an indigenous language is time consuming and not likely to be achieved timeously by qualified English and Afrikaans-speaking clinicians, it is proposed that the development of clinicians' communication skills should incorporate learning to work more efficiently with interpreters in an interpreted interview. This would facilitate easier access as well as a higher quality of service provision in health care, to speakers of indigenous languages.

It is important that those involved in an interpreted interview have some understanding of the impact of cultural factors and what is at stake in an interpreting relationship. The findings from this research support the findings of Swartz (1998) and Crawford (1999), who indicated that just as interpreters need training in specific linguistic skills and counselling techniques, clinicians also need training in the effective use of interpreters. As Putsch (1985) suggests, including both the health care providers and the interpreter in the training process, allows for it to neutralise some of the common problems found to occur in interpreted consultations. It is proposed that training should deal with the special nature of cross-cultural communication as well as bio-medical and cultural theories, practices and terminology.

As was called for by the Ministry of Education, many changes are occurring in the curriculum of students training to be health care professionals. It has been acknowledged that the undergraduate training of clinicians needs to include aspects of cross-cultural communication as well as an understanding of the differing cultural groups being treated. Indeed, if the health problems that face the country are to be appropriately addressed,

University of Cape Town

health professionals must not only be trained with clinical and health aspects of these problems, but also with the social, economic and cultural context within which they occur. It has been proposed that *"health professionals must understand the life conditions, belief systems and the cultural practices of the rainbow nation, and they must be equipped to deal with the change and diversity, in particular the appreciation, tolerance and the embracing of different views and ideas.....the curriculum must be embedded and give effect to the fact that in terms of the Constitution, access to health is a basic human right."* (Asmal, 2000 in Klein, London & Perez, 2001).

Ncayiyana (1999) has also highlighted the need for restructuring of the medical curriculum, in such a way as to produce doctors who understand the health needs of the disadvantaged communities. The government's 1997 *White Paper for the Transformation of the Health System in South Africa* directs that education and training programmes should be aimed at recruiting and developing personnel who are competent to respond appropriately to the health needs of the people they serve. Thus, within the field of Speech-Language and Hearing Therapy, the curriculum is devised on an annual basis in accordance with the needs of the country.

As Swartz et al. (1997) have indicated, although there have been various attempts to train interpreters for the health services in South Africa, there has been no parallel formal training for clinicians in how to work with interpreters. The expertise of clinicians in making use of interpreters has been questioned, particularly because clinicians often do not consider the complexity of the interpreter's role (Muller, 1994). The traditionally dyadic relationship between clinician and patient becomes triadic and decidedly more complicated, with the presence of an interpreter. Swartz et al. (1997) point out that most clinicians do not have training in sociolinguistics and similar disciplines. This lack of training, in combination with the low status of the interpreter in South Africa in the context of racial politics, may result in clinicians being unlikely to theorise about the implications of different models of interpreting for the provision of democratic health care (Swartz et al., 1997).

As Penn suggests (2000), considering that Speech-Language and Hearing Therapists throughout the world participate in clinical interactions with bilingual and multilingual clients, and that these interactions often involve a third party interpreter and have special

University of Cape Town

characteristics, these characteristics should be included in the training and preparation of the clinician. This is particularly important in South Africa where relationships of unequal power, historical influences and a history of labelling besets the profession of Speech/Language and Hearing Therapy (Penn, 2000).

Thus, the acquisition of communication skills is largely neglected in both the training and the functioning of public service professionals (De Ridder, 1999). Even within the academic fields underpinning these professions, little or no attention is paid to communication skills in general, let alone to the skills pertaining to the complex field of intercultural communication. Public servants or health professionals encounter non-compliance, misunderstanding and conflict when attempting to communicate with clients who can't speak their language. Previously, the onus lay with the client to learn the language of the service provider, or bring along a family member of friend that could interpreter for them. Considering the existing 'ad hoc' status of interpreting services countrywide and internationally, there is a growing awareness that service providers need to accept some responsibility for their interaction with interpreters and learn to work with them efficiently and in a manner that facilitates accurate transfer of information and comfort of interpersonal interaction. It is hoped that the training guidelines developed from the findings of this study will contribute towards this objective.

University of Cape Town

4.1.5 Need for Genuine Commitment from Stakeholders

The starting point for addressing language issues in institutions would be a willingness on the part of the institution to examine its services and systems for equity, access and appropriateness to the communities who make use of them (Drennan, 1998). In addition, it has been established that the power relations that operate to the detriment of patients in our health care system are complex and are unlikely to be drastically modified by supplying interpreters in isolation. Concurrent with this need for interpreters, is the institutions' commitment to a general strategy of changing to a more culturally sensitive patient-centred model of care. As Crawford (1999) suggests, this necessarily involves doctors relinquishing some degree of power and control with in medical interviews, which is likely to meet with some resistance. In addition, a consideration of the provision of linguistically equitable services, should be embedded in an overall strategy to create and deliver culturally appropriate and equitable services to all patients.

It is evident that a number of strategies could be enforced to bridge the linguistic and cultural barriers existing between clinicians and patients. The most obvious strategy would be providing professional, trained interpreters who are acknowledged for the important role they play in the provision of health care services and thus are appropriately remunerated. In addition, there is a dire need for clear outlines and job descriptions for these interpreters. It is recommended that training institutions attempt to attract Black students to their courses, to allow for more direct patient-doctor contact in the future. Considering that both the training of Black clinicians and the employment of interpreters within health care institutions is likely to take a considerable amount of time (estimated as decades by Swartz et al., 1997), the training of clinicians in interpreting practices is essential. Furthermore, the importance of a participatory framework in dealing with research in language issues is emphasised and recommended. Once again, the success of this venture, providing linguistically equitable service provision in health care, would be dependent on the collaboration and partnership of government, communities, health care providers and interpreters alike.

University of Cape Town

5. CONCLUSIONS & IMPLICATIONS

In this study, the researcher set out to investigate the differences between trained and untrained interpreters within the initial assessment interview in the field of Speech-Language and Hearing Therapy. More specifically, accuracy, interpersonal interaction of members of the triad, need for and roles of the interpreter, the impact of training and satisfaction of the informants, as well as how these aspects interrelate, were examined. What emerged is that in part, the differences between trained and untrained interpreters could be most effectively examined within the themes of transactional and interactional behaviours. The use of qualitative and quantitative methods of analysis proved to be an effective means of analysing what proved to be a complex issue. Indeed, it became very clear that interpreting is a complicated task that extends far beyond the mere interpretation of language.

A number of primary differences between trained and untrained interpreters emerged in this study, the first of which was differences in accuracy. The interpreted interviews using trained interpreters revealed considerably more accuracies than those with untrained interpreters. The reasons for the accurate translations were examined in-depth and of significance is that the considerable amount of accuracies found in the trained interpreted interviews were thought to be partially a result of the skills acquired during training, in combination with the presence of field-specific knowledge in the trained interpreters. Examination of the inaccuracies revealed that a large proportion of the trained interpreters' inaccuracies had positive effects, such as increasing understanding or facilitating cultural brokerage. Contrastly, the majority of the untrained interpreters' inaccuracies contributed negatively to the interpretation. This implies that the majority of the trained interpreters' mistranslations were helpful, while the majority of the untrained interpreters' mistranslations were unhelpful. These findings have significant implications and highlight the potential inadequacy of health care services to the majority of the South African population who are forced to make use of 'ad hoc' interpreting practices.

Furthermore, a lack of the use of strategies to facilitate accuracy and understanding was noted in the untrained interpreted interviews, in contrast to the trained interpreted interviews. In addition, the trained interpreters regularly used strategies to ensure that the

University of Cape Town

clinician and the caregivers were understanding, while the untrained interpreters used strategies when they were not understanding what the clinician or caregivers had said. This resulted in the clinician and caregivers mostly understanding the trained interpreters, while they did not always understand the untrained interpreters to the same extent.

Examination of the interpersonal interaction of the informants revealed that the untrained interpreters tended to over-identify with the caregivers due to their similar backgrounds, while the trained interpreters identified more with the clinician as a professional. The clinician reported feelings of disconnection from the caregivers when untrained interpreters were employed due to their over-identification with the caregivers.

The use of the revised MAT allowed for the positive contribution of interpreters to be revealed, which is in contrast to past research that has largely addressed the negative impact of interpreters within the interpreted interview. In addition, examination of the reasons for the accurate translations as well as the strategies employed to facilitate effective transaction and interaction, allowed for the development of a set of training guidelines for interpreters and clinicians working within an interpreted interview.

Findings from this study attested to the multiple roles expected of the interpreter within an interpreting situation. However, differences were noted in the roles that the trained and untrained interpreters portrayed. The trained interpreters tended to vacillate between several roles very effectively, including that of cultural broker, patient advocate and member of a team, while the untrained interpreters were more prone to being patient advocates, or a supporter or confidante to the caregiver. Once again, the untrained interpreters' over-identification with the caregivers is highlighted. This implies that the untrained interpreters defined their role as 'helping the caregiver' above any other role, while the trained interpreters acknowledged the need for acting more like 'mediators' and thereby meeting the needs of both the clinician and the caregiver. Thus, the implications of these findings are significant and favour the appropriate training of interpreters.

Furthermore, these results indicate that the success of the interpreted interview is dependent on the effectiveness of the interpreters in both transaction of information and interpersonal interaction of the interpreters, and thus all of these aspects should be considered in the training of interpreters within health care services.

University of Cape Town

Much past research has focused on the training of interpreters in health care, while this study also highlighted the equally important need for training of clinicians in interpreting practices. Training of clinicians should reflect a sensitivity to cultural issues, as well as heightened awareness of the pitfalls of interpreting situations. Furthermore, strategies that facilitate effective transaction of information and appropriate interpersonal interaction between all members of the interpreting triad should be emphasised.

Like past research in this area, the findings from this study confirmed the well-recognised need for interpreters in health care services. It was also evident that the existing socio-political situation in South Africa is unique, and this leads to an even more distinctive and dire need for interpreters within this country. Within the South African context, interpreters are needed to address issues related to accessibility of health services connected to linguistic, cultural and ethical needs. Furthermore, the desperate need for training of interpreters, and equally importantly, training of clinicians in working more effectively with interpreters was established. The importance of interpreters receiving field-specific training was also acknowledged. Finally the need for the professionalisation of interpreters was re-established as was the need for policy formation regarding interpreters in health care services.

Considering the period of political and economic transformation, as well as the transformation of the health services and the education of health professionals currently transpiring in South Africa, it is hoped that these findings may contribute towards informing policy, as well as the training of interpreters and clinicians providing health care services. It is proposed that "there is no time like the present" to present findings to authorities and inform policy.

This research differs from past research in the area of interpreting in that, to the best of the researcher's knowledge, it is the first time that trained and untrained interpreters were systematically compared on the basis of transactional and interactional behaviours. Thus the complexity of the interpreting situation was highlighted and acknowledged. Furthermore, past research has largely focused on the perceptions of clinicians and interpreters within the interpreting triad, and largely failed to acknowledge the importance of the caregivers' perceptions. In this study, all informants perceptions and views were considered, which resulted in the accumulation of very rich data. The approach adopted in

University of Cape Town

this study was thought to equally acknowledge the opinions and perceptions of all participants within the interpreted interview. Furthermore, all informants provided valuable and much needed insight into the dynamics of the interpreting situation.

The reader is reminded that the clinician selected and employed in this research had good interpersonal interaction skills with informants. Furthermore, the differences between trained and untrained interpreters were examined within an established setting conducive to comfort and ease of communication between informants. Thus, interpreting was examined within a profession and with a clinician who have largely adopted a patient-centred approach. This offered a platform to examine the trained and untrained interpreters in a more optimum environment. It could be argued that this is not necessarily a realistic situation, since a patient cannot control the clinical environment or the quality of the clinician offering a service. However, the use of a clinician with poor interpersonal interaction skills, might have exacerbated the differences between the trained and untrained interpreters, and it would have been difficult to determine whether the exaggerated differences between trained and untrained interpreters were due more to interpreter than to clinician traits. In addition it might have resulted in different responses from the caregivers, which could have influenced the findings. It is also of importance that all of the untrained interpreters were caregivers of hard of hearing or deaf children, which was thought to increase their awareness of the profession and the initial assessment interview situation. It is proposed that complete lack of exposure to the field of Speech-Language and Hearing Therapy, might have adversely affected the performance of the untrained interpreters. In addition, it is felt that the selected untrained interpreters showed a greater degree of empathy towards the caregivers, because of their heightened awareness of hearing impairment, which might not have been the case had other lay or untrained interpreters been selected.

A number of methodological issues were raised in this study. Firstly, difficulty standardising the language proficiency of the untrained interpreters became apparent. The subjective impressions of the untrained interpreters' expressive proficiency in English, appeared to deteriorate during the taxing job of interpreting. Therefore there is a need for a more formal screening process in research on interpreting practices and in training of interpreters.

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Secondly, the researcher in this study was disadvantaged by not being a first language Xhosa speaker. There are ethnomethodologists who believe that speaking the language under investigation is a prerequisite for ethnomethodological research. However, valuable time and funds were spent undertaking multiple transcriptions, translations and verification of translations to ensure reliability of the data to be analysed. There have been numerous methods proposed for dealing with reliability of translation in studies such as these, such as back-translation, multiple raters and verification. However, this will remain a contentious issue since no one method has been proven to be more effective than the other. Despite this, it is noted that the use of multiple raters in this study was thought to increase reliability and the final results of this study are indeed considered to be reliable.

Thirdly, the small sample size in this study prevented the use of statistical analyses. However, it is felt that this was not a limitation in this particular study due to the magnitude of the data that was collected for the effective use of thematic analysis of the post-interview sessions. Furthermore, increasing the sample size might have resulted in the richness of the data disintegrating.

Lastly, the interpreted consultation was conducted in one setting only, the initial assessment interview. Considering the differing natures of other clinical settings, such as those of feedback and counselling sessions, different aspects might have emerged as being distinct within these settings, and thus might have further highlighted the differences between trained and untrained interpreters across setting types. Therefore, it is recommended that research be expanded to other settings in future.

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Numerous theoretical, clinical and future research implications emerged from this study.

5.1 THEORETICAL IMPLICATIONS

The already documented need for trained interpreters in health care was reiterated in this study, as was the need for linguistically equitable service provision in health care. Supplementary knowledge regarding the differences in trained and untrained interpreters emerged, as well as additional knowledge regarding the numerous and often conflicting roles expected of the interpreter within the interpreting situation.

Novel means of evaluating the proficiency of interpreters in health care emerged, extending to an acknowledgement of the importance of both transactional and interactional behaviours within interpreted consultations. Considering the importance of the role that interpreters play in health care, it should not be automatically assumed that a training course instills them with the necessary skills to be good interpreters. Furthermore, language proficiency and innate characteristics emerged as being contributors to the performance of the untrained interpreters. Thus, it is proposed that interpreters should be screened for language competency as well as the necessary prerequisite criteria needed for interpreting. In addition, training in transactional and interactional behaviours, as well as field-specific knowledge where necessary, is considered essential. In addition, interpreters should be evaluated on an ongoing basis in the above-mentioned skills, with the focus of the evaluation not being purely to highlight negative traits, but also to emphasise and encourage the development of positive interpreting practices. Furthermore, since this study provided additional knowledge regarding the training and role of clinicians in an interpreting situation, evaluation of proficiency should extend to the functioning of the clinician within the interpreted interview.

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5.2 CLINICAL IMPLICATIONS

The clinical implications of training clinicians in effective interpreting practices are vast. It is recommended that workshops are conducted within existing educational and health care institutions to train clinicians in effectively working with interpreters, and to present the suggested training guidelines developed from the findings of this study. These guidelines are felt to be applicable across all disciplines in the health sector.

The Education Development Units at the existing universities need to be approached to provide input into the training curriculum regarding working with interpreters. In addition, guidelines need to be provided from these findings on strategies to employ when working with untrained as opposed to trained interpreters. Since 'ad hoc' interpreting practices are unlikely to change in the near future, an awareness of the pitfalls of using untrained interpreters is crucial. These guidelines should be shared in workshops to interested parties involved in health care services. This extends to all areas of service provision.

It is the purpose of the researcher to share these findings with academic institutions, the general public, and amongst decision-making authorities so as to inform policy and lobby for interpreter posts. It is hoped that the findings from this study will provide some social benefit, since it is believed that if social and economic benefit cannot be achieved from research, then it has fulfilled no real purpose.

5.3 FUTURE RESEARCH IMPLICATIONS

Areas which require further research are the examination of trained and untrained interpreting practices across differing setting types within the field of Speech-Language and Hearing Therapy. Feedback and counselling sessions are felt to be more emotive in nature, and thus examination of the effect of emotive content on transactional and interactional behaviours across trained and untrained interpreters within an interpreted situation, should be investigated.

In addition to this, trained and untrained interpreting practices should be examined across differing fields within the health services, since each field is thought to bring differing dynamics into the interpreted interview. In keeping with the current trend towards increasing patient centredness and promoting multicultural practices in health care services, further examination of interpreting practices should be conducted within fields focusing on these practices. Furthermore, the role of the interpreter in medical consultations should be examined within a more culturally sensitive approach, using a cultural narrative as a means of validating the patient's story and experience of their illness. The dynamics of this type of interview are in sharp contrast to the traditional case history approach and the functioning of the interpreter in this situation should be evaluated. This approach raises many ethical issues regarding the autonomy of the interpreter, which should be investigated.

Finally, additional research should focus on developing cost-effective models for interpreting services within health care. This would provide support for decision making authorities to inform policy in the area of interpreters in public services, particularly health care, as well as ensure sustainability of services.

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"Thought is the blossom; language the bud; action the fruit behind it."

Ralph Waldo Emerson

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University of Cape Town

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Legislation:

Act 200 of 1993: Constitution of the Republic of South Africa, 1993.

Act 108 of 1996: Constitution of the Republic of South Africa, 1996.

8. APPENDICES

APPENDIX A.....183
Official Languages of the Provinces of South Africa

APPENDIX B.....184
Appendix B1: Relevant Sections on Language Provision within the 1993 Constitution of the Republic of South Africa.

Appendix B2: Relevant Sections on Language Provision within the 1996 Constitution of the Republic of South Africa.

APPENDIX C.....186
Job Description for Community Interpreters in Formal Language Project

APPENDIX D.....187
Excerpt from Coded Transcript: MAT Analysis

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Appendix A

Official Languages of the Provinces of South Africa

1. EASTERN CAPE (EC): Xhosa, Afrikaans, English, Zulu, Southern Sotho.
2. FREE STATE (FS): Afrikaans, Southern Sotho, English.
3. GAUTENG (GT): Zulu, Afrikaans, Northern Sotho, English.
4. KWAZULU-NATAL (KZN): Zulu, English, Afrikaans
5. MPUMALANGA (MPL): English, Swati, Afrikaans, Ndebele.
6. NORTHERN CAPE (NC): Afrikaans, Tswana, English, Xhosa.
7. NORTHERN PROVINCE (NP): English, Northern Sotho, Afrikaans, Tsonga, Venda
8. NORTH WEST (NW): Tswana, English, Afrikaans.
9. WESTERN CAPE (WC): Afrikaans, English, Xhosa.

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	EC	FS	GT	KZN	MPL	NC	NP	NW	WC	Total
English	✓	✓	✓	✓	✓	✓	✓	✓	✓	9
Afrikaans	✓	✓	✓	✓	✓	✓	✓	✓	✓	9
Zulu	✓		✓	✓						3
Xhosa	✓					✓			✓	3
Tswana						✓		✓		2
North Sotho			✓				✓			2
South Sotho	✓	✓								2
Tsonga							✓			1
Venda							✓			1
Swati					✓					1
Ndebele					✓					1

(Source: State Language Services in Drennan, 1998)

Appendix B1

Relevant Sections on Language Provision within the 1993 Constitution of the Republic of South Africa.

Languages

3. (3) Wherever practicable, a person shall have the right to use and to be addressed in his or her dealings with any public administration at the national level of government in any South African official language of his choice.

3. (5) A provincial legislature may, by a resolution adopted by a majority of at least two-thirds of all its members, declare any language referred to in section (1) (Official languages) to be an official language for the whole or any part of the province and for any or all powers and functions within the competence of that legislature, save that neither rights relating to language nor the status of an official language as existing in any area or in relation to any function at the time of the commencement of this Constitution, shall be diminished.

3. (6) Wherever practicable, a person shall have the right to use or be addressed in his or her dealings with any public administration at the provincial level of government in any one of the official languages of his or her choice as contemplated in subsection (5).

3. (9) Legislation, as well as official policy and practice, in relation to the use of languages at any level of government shall be subjected to and based on the provisions of this section and the following principles:

(a) The creation of conditions for the development and for the promotion of the equal use and enjoyment of all official South African languages;
(b) The extension of those rights relating to language and the status of languages which at the commencement of this Constitution are restricted to certain regions;
(c) The prevention of the use of any languages for the purpose of exploitation, domination or division;
(d) The promotion of multilingualism and the provision of translation facilities;
(e) The fostering of respect for languages spoken in the republic other than the official languages and the encouragement of their use in the appropriate circumstances; and
(f) The non-diminution of rights relating to language and the status of languages existing at the commencement of this constitution.

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Appendix B2

Relevant Sections on Language Provision within the 1996 Constitution of the Republic of South Africa.

Languages

6. (1) The official languages of the republic are Sepedi, Sesotho, Setswana, Tshivenda, Xitsonga, Afrikaans, English, isiNdebele, isiXhosa and isiZulu.

6. (2) Recognising the historically diminished use and status of the indigenous languages of our people, the state must take practical and positive measures to elevate the status and advance the use of these languages.

6. (3) National and provincial governments may use particular official languages for the purposes of government, taking into account usage, practicality, expense, regional circumstances, and the balance of the needs and preferences of the population as a whole or in respective provinces, provided that no national or provincial government may use only one official language. Municipalities must take into consideration the language usage and preferences of their residents.

6. (4) National and provincial governments, by legislature and other measures, must regulate and monitor the use by those governments of official languages. Without detracting from the provisions of subsection (2), all official languages must enjoy parity of esteem and must be treated equitably.

6. (5) The Pan South African Language Board must –

a) promote and create conditions for the development and use of
   (i) all official languages;
   (ii) the Khoi, Nama and San languages; and
   (iii) sign language.
b) promote and ensure respect for languages, including German, Greek, Hindi, Portuguese, Tamil, Telunga, Urdu, and others commonly used by communities in South Africa, and Arabic, Hebrew, Sanskrit, and others used for religious purposes.

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Appendix C

Job Description for Community Interpreters in Formal Language Project

JOB SUMMARY:

To facilitate communication between isiXhosa-speaking and non-isiXhosa –speaking health care providers by offering interpreting services and also ensure that the Xhosa-speaking patients obtain appropriate health care and service.

PRINCIPAL DUTIES:

- To interpret for isiXhosa-speaking individual patients in their interaction with health care providers in accordance with the project's code of practice.
- To identify needs of the isiXhosa-speaking patients in respect to health care services.
- To advise patients of their rights and choices in regard to health care.
- To prepare proposals for submission to management of health care facility in conjunction with the co-ordinator/director.
- To take appropriate action and ensure that the patient receives appropriate service and that the health care provider understands the needs of the patient. This may require the interpreters to challenge discriminatory or culturally insensitive behaviour on the part of the health care provider.
- To assist with counselling when necessary.
- To observe confidentiality at all times.
- To help with social problems which may arise whilst the patient is attending the health facility.
- To assist with health promotion (e.g. give appropriate health message to patients, assist with directions of taking medications, referrals etc.)
- To keep records of work done with detailed information of problem areas and present weekly reports in both written and oral form.
- To attend weekly in-service education sessions.
- To be able to function effectively within a multidisciplinary health team.

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Appendix D

Excerpt from Coded Transcript: MAT analysis

Cl: **/Okay, alright, um, and you mentioned that she was at Red Cross/ for the speech problem and for the balance. /What did they explain to you about her problems?/** O-27

UI2: **/You said she was at Red Cross,/ so what did they tell you about her, when you took her to Red Cross, /what did they say exactly at Red Cross?/**
O-27 A+10

Cg: /They didn't say what she has, /just said she will be right./

UI2: /Mmm, okay, when she went to Red Cross, they say, they, she's going to be fine,/ she's going to talk a little bit./ Do you understand what I'm saying?/
A-36 A+12

Cl: /Okay./
A+13b

UI2: /Ya, so they sent to, to those schools./

Cl: /Right./
AΦ A-32 AΦ

UI2: /And they say she's going to be fine./ What can I explain..... /Ya she, they say it's going to be fine./ She's going to talk a bit./ AΦ

Cl: **/Okay, alright, can you describe for me mama, what the problem is with her speech?/ What are the problems with her speech?/** O-19
OΦ

Cg: /Is she asking about the problem of the speech?/

UI2: **/No, tell her..... /** A+13
/Eh, main problem of it, main problem? (to clinician)/

Cl: /Yes./
A-32

UI2: **/Yes, the main, main problem that she has/ anything that she's got, exactly./**
OΦ

Cg: /The speech only./
A-38

UI2: **/And the balance?/**
OΦ

Cg: /Yes, that one also./
OΦ

UI2: /That one also./

Cg: /The main thing that I want to be done to her is, I want her to be able to talk./
AΦ

UI2: /To talk?/

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Oϕ
Cg: /Ya, talk./

UI2: /She wants her to speak properly as the other children do, ya./
O-27
Cl: /Alright, um, I understand that there is a problem with the speech, /um, what I want to know is um, is the problem with, um, the sounds,/ does, is there problems with um, her pronounciation/ or speaking out the sounds?/ O-24
A+2 A+2
UI2: /When she is talking, is she able to explain/ like "mama", /"tata" or any other words./
O-27 O-23 O-23
Cg: /Yes, she can speak, /like is she says "mama, here it is" /or "mama, I want"./

UI2: /Does she say it right, does she pronounce it right,/ does she explain the word right as you and I are speaking?/ A+10
O-27 Oϕ O-27
Cg: /She speaks in bursts, she speaks in bursts,/ then she closes her eyes/ and then she finishes./
A-32
UI2: /Ya, the problem, the problem, it's difficult for her to talk properly, and just ...../
Oϕ
Cl: /Okay to say the sound./
Aϕ
UI2: /To say the sounds, ya, to her, to say the sound./

Cl: /Okay./

Cl: /Mama, do you feel that um, she understands you when you ask her for something,/ or to do something?/

UI2: /When you ask her something, does she listen to you/ and maybe do it?/
O-27
Cg: /Yes, she listens to me/ and does it./
Aϕ
UI2: /Ya, she does understand her,/ she does understand her./....
/When you maybe say "wash your takkies" /or to brush her shoes, can she do that?/
Oϕ A+12 A+12
Cg: /When you tell her to wash her shoes?/

Key: UI2 – Untrained interpreter number two	O – Omission
Cl – Clinician	A – Addition
Cg – Caregiver	+ – Positive contribution
/ – beginning or end of proposition	- – Negative contribution
Bold – English to Xhosa	ϕ – Neutral
Normal – Xhosa to English	Number – Corresponds to cause of mistranslation on revised MAT sheet

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